CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1940

KP 23907

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. ☐ Establish retention period for records which are accumulating daily.

B. ☐ Dispose of present accumulation, no additional accumulation anticipated.

C. ☐ Microfilm and destroy originals.

D. ☒ Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES ☐ NO ☒

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber, M.D. Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A.	B.	C.
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	☐ To be sold as scrap or waste paper	☒ To be Burned or shredded	☐ Historical, (to be transferred to Dept. of Legislative Reference.)

REMARKS:

C P Force 3/29/63
Records Management Officer Date

...VALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RET... ROOM 408 ...

1. APPROVED: ...CITY AUDITOR

2. APPROVED: ...

3. APPROVED: ...

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

G24501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1621 B

Registered No. G24501

Write the causes of death clearly and legibly. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 N. Pulaski St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 N. Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Peter Franz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Mary Alice Franz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9 1851

8. AGE: Years	Months	Days	If less than one day
93	6	30	9 hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Retired Grocery Clerk

11. Industry or business

FATHER
12. Name Jacob P. Franz
13. Birthplace Germany

MOTHER
14. Maiden Name Mykenodin
15. Birthplace Germany

16 (a) Informant Adelaide M. Gately
(b) Address 415 N. Pulaski St.

17 (a) Burial (b) Date thereof Jany 11/1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Whitestone Methodist
Location Whitestone Pa

18 (a) Funeral director Harry A. Armacost
(b) Address 4204 Ridgewood Ave

19 JAN 9 - 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1945, at 5:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 19 to Jan 9 1945, and that I last saw him alive on Jan 9 1945.

	Duration
Immediate cause of death Cardiac Failure due to debility	one month
Due to Age	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. H. Phillips M. D.
Address 1939 Edmondson Ave Date signed

VS 150

G24502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

G24502 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1750 E Baltimore St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Stephanie Joy Paul

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9, 1944

8. AGE: Years	Months	Days	If less than one day
0	10	-	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Sidney Paul
13. Birthplace New York City

MOTHER
14. Maiden Name Bernice Greenfeld
15. Birthplace Baltimore Md

16 (a) Informant Bernice Paul
(b) Address 1715 E Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan, 10, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) JAN 9 - 1945 (Date rec'd by registrar) Registrar

Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/9 1945, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9 1945 to 1/9 1945 and that I last saw h[illegible] alive on 1/9 1945

Immediate cause of death: Pulmonary edema — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary edema Congenital ht. disease M Bicuspid Aortic Valve

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert Farbman
Address Sinai Date signed 1/12/45

G24503

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G24503 Registered No. 127a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Strathmore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Fink

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Elizabeth M. Cooper | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12 1862

8. AGE: Years 82 | Months 4 | Days 24 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Pharmist.

11. Industry or business

FATHER
12. Name Wm. Fink
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Mrs. Elizabeth Fink
(b) Address 2906 Strathmore Ave

17 (a) Burial (b) Date thereof 1-10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 2901 Frederick Ave.

18 (a) Funeral director Hamill Withers
(b) Address 4101 Edmondson Ave.

JAN 9 - 1945 (Date received by Registrar) (b) Livingston Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6/45 1945, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25 1944, to 1/6 1945, and that I last saw him alive on 1/6 1945.

Immediate cause of death: Ventricular fibrillation — Duration: 30 min.

Due to: coronary occlusion — 1 hr.

Due to:

Other Conditions: Recent cholecystectomy

(Include pregnancy within 3 months of death)

Date of operation 12/26/44

Major findings of operation: Hydrops Gallbladder — cholecystitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen A Stone M. D.

Address University Hospital Date signed 1/6/45

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied: the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FORTSON G24504

G24504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 94 B 32

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3570 Hilton Road
(c) Hospital or institution: Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 194 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 332 Mt Vernon Place (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Maud Griff Fortson

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Dryden S. Fortson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10-1873

8. AGE: Years 71 | Months 2 | Days 30 | If less than one day hr. min.

9. Birthplace Marengo Iowa (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Chas Harold Groff

13. Birthplace Marengo Iowa

MOTHER 14. Maiden Name Elizabeth Dunham

15. Birthplace Wisconsin

16 (a) Informant Mrs Shriver

(b) Address 3570 Hilton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan-11-45 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Edmondson Ave

18 (a) Funeral director Walter Burke Bentley

(b) Address 1919 W. North Ave

19 (a) JAN 9 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9th 1945, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1939 to Jan 9th 1945 and that I last saw h alive on Jan 8. 1945

Immediate cause of death	Duration
Hemiplegia (Left)	3 days
Due to Hypertension & arteriosclerosis	6 yrs
Due to Senility	7
Other Conditions Vincents Angina	2 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice A. Krauss M. D.

Address 2360 Eutaw Place Date signed Jan 9 1945

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G24505 BALTIMORE CITY HEALTH DEPARTMENT G24505
CERTIFICATE OF DEATH V122 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette + John St.
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5805 Clear Spring Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. GRACE LEE V. GLADDING

3 (b) If veteran, name war W
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	W	Married

6 (b) Name of husband ~~or wife~~ Bennett S. Gladding
6 (c) If alive, give age 999 years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1899

8. AGE: Years	Months	Days	If less than one day
45	5	1	2 hr. 55 min.

9. Birthplace BALTIMORE, Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER 12. Name Walter Lee Vint
13. Birthplace Manchester Va

MOTHER 14. Maiden Name Grace E. Moore
15. Birthplace Va.

16 (a) Informant Bennett S. Gladding
(b) Address 5805 Clear Spring Rd

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 1/12/45 (month) (day) (year)
(c) Cemetery or crematory Loraine
Location West Lawn Md

18 (a) Funeral director Tillson & Son
(b) Address 12 N. Paca St

JAN 9 - 1945 (Date received by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1945 at 2 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 4 1945 to Jan. 9 1945, and that I last saw her alive on Jan. 9 1945

Immediate cause of death: Intestinal Obstruction post Operative — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Jan. 5, 1945
Major findings of operation: Diagnosis deferred for Pathological Report of autopsy: Intestinal Obstruction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. S. Laird III M. D.
Address Womens Hospital Date signed 1-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

G24506 G24506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 12B

YA-999

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs., 6 mos., 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 6400 Old York Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cleveland Ports

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 21, 1885
8. AGE: Years 59 | Months 1 | Days 17 | If less than one day ... hr. ... min.
9. Birthplace Missouri (Town, county, and state)
10. Usual Occupation Clerical
11. Industry or business —

FATHER
12. Name Thomas Ports
13. Birthplace Md.

MOTHER
14. Maiden Name Barbara Price
15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS (RECORDS)
(b) Address

17 (a) Burial (b) Date thereof 1/11/45 (month) (day) (year)
(c) Cemetery Grace Methodist Church
Location Hampstead Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St Huntington Williams, Md

19 (a) 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7, 1945 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 29, 1935 to Jan. 7, 1945; and that I last saw him alive on Jan. 7, 1945.

Immediate cause of death	Duration
Heart Failure	7 days
Due to Pulmonary Tuberculosis	11 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] Leonard M. D.
Address Baltimore City Hospitals Date signed 1-8-45

VS 150

G24507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24507 X 61

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Talbot
(c) City or town Easton
(If outside city or town limits, write RURAL and give town)
(d) Street No. 127 S. Harrison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Lida Miles

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) ~~Single, married~~, widowed, or divorced: Widowed
6 (b) Name of husband Benjamin N. Miles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/20/85

8. AGE: Years 56 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Easton, Maryland
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Annalls Tull
13. Birthplace Trappe Md.

MOTHER
14. Maiden name Jane Estella Tull
15. Birthplace Dorchester Co. Md.

16 (a) Informant Mrs. Ruth E. Bates
(b) Address 1826 N. Chapel St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1/11/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Balto
Location " Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St

19 (a) 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7, 1945, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1945, to 1/7 1945, and that I last saw her alive on 1/7 1945.

Immediate cause of death: Cerebrovascular accident — Duration

Due to Hypertensive C.V. disease C grade III decompensation

Due to

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund Scavone M. D.
Address St. Joseph's Hosp Date signed 1/12/45

93d

G24503 G24503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caturus Saratoga
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 325 E. Biddle (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET HEILMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 5th 1939

8. AGE: Years	Months	Days	If less than one day
6	0	2	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank Heilman
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Hassett
15. Birthplace Balto. Md.

16 (a) Informant Mrs Elizabeth Hassett
(b) Address 1207 Holbrook st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Wilson Funeral Home
(b) Address 1241 E. Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7, 1945 at 4:03 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute pulmonary Edema due to 2+3° burns 90% of body

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/1 at M.
(b) Where did injury occur? At home
(c) Did injury occur at home, on farm, industrial place, in public place? home. While at work? Natural gas plant
(d) Means of injury Fire Caught in flames

23. Signature John R. Sturs M.D.
Medical Examiner.
Date signed Jan 7, 1945

VS 151

G24509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

G24509

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 hrs.
(e) Length of stay in Baltimote (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Defense Housing, G-36, Fairfield (If rural give location) Md.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl-Subach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1945

8. AGE: Years | Months | Days -1- | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Adolph Subach
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Katherine Sunseree Pg. Catherine Chatnick
15. Birthplace Swanton ~~Maryland~~ or Pa.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 19 1945 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Mem
Location Glen Burnie, Md

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 (a) JAN 9 - 1945 (Date rec'd by registrar) (b) Registrar

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8, 1945 19 , at 2:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-7 1945, to 1-8 1945, and that I last saw h-r alive on 1-8 1945.

Immediate cause of death Intracranial Hemorrhage — Duration 1 day

Due to

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis W. Halfpiak M. D.
Address BCH Date signed 1-9-45

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G24510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G24510

Registered No. L4747

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 814 No Gay St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 18yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 814 No. Gay (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Selina Bowler

3 (b) If veteran, name war No | 3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband ~~or wife~~ James Bowler
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) 10/25/1894

8. AGE: Years 50 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Winnsboro S. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER 12. Name George Robinson
13. Birthplace Winnsboro, S. C.

MOTHER 14. Maiden Name Suckie Harris
15. Birthplace Winnsboro, S. C.

16 (a) Informant Gertrude Alexander.
(b) Address 1424 Harford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 10 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St.

JAN 9 - 1945 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1945 at 8.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 1944 to 1/5 1945, and that I last saw her alive on 1/5 1945.

Immediate cause of death Lobar Pneumonia — Duration

Due to —

Due to —

Other Conditions Ca of uterus.

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Reuold B Lightston M. D.
Address 2129 Druid Hill Ave. Date signed 1/6/45

VS 150

108

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G24511 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 616 S. Milton ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 616 S. Milton ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Salzig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15 1864

8. AGE: Years	Months	Days	If less than one day
80 81	9	22	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jacob Salzig
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Grubmann
15. Birthplace ?

16 (a) Informant Mrs Agnes Wagner
(b) Address 616 S Milton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 10 1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem
Location Balto. County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester St

JAN 9 1945 (Date received by registrar) (b) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1945, at 10.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15-44 to Jan 8 1945 and that I last saw h- alive on Jan 5 1945

Immediate cause of death	Duration
Complete Intussusception	
Due to Arterio Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. R. Mm. Jones M. D.

Address 2936 E Balto Date signed 1-8-45

G24512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 c

G24512
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County
(c) City or town Faundale
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Mard

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 10, 1876

8. AGE: Years: 68 | Months: 9 | Days: 25 | If less than one day: hr. min.

9. Birthplace: York Co Pa
(Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business: Brick Work

FATHER
12. Name: Lewis Cooper
13. Birthplace: York Co Pa

MOTHER
14. Maiden Name: Dora Doyle
15. Birthplace: York Co Pa

16 (a) Informant: Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 11 1945 (month) (day) (year)
(c) Cemetery or crematory: Mt Nebo
Location: Delta Pa

18 (a) Funeral director: Howard Heath
(b) Address: Fawn Grove Pa

JAN 9 - 1945 (Date received by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1945, at 9:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of skull

Due to:

Other Conditions: ?
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: January 5, 1945 M.
(b) Where did injury occur? Faundale, Penna.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Struck by auto

23. Signature: Robert Lee Graham M.D.
Medical Examiner.
Date signed: Jan 9 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 E.

Registered No. G24513

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4701 ~~West Over~~ Forest Glen Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 D
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4701 ~~West Over~~ Forest Glen Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie H. Haines

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1876

8. AGE: Years	Months	Days	If less than one day
68	9	12	hr. min.

9. Birthplace Charlestown, W. Va.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Mr. Rust
13. Birthplace West Virginia

MOTHER
14. Maiden Name Annie Carter
15. Birthplace Virginia

16 (a) Informant Mrs. William Tracy
(b) Address 4204 Falls Road

17 (a) Burial (b) Date thereof Jan. 10, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Mathias Lawrence
(b) Address 4510 Liberty Heights Ave.

19 (a) JAN 10 1945 Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1945 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to Jan 7 1945 and that I last saw her alive on Jan 6 1945.

Immediate cause of death	Duration
Myocardial Insufficiency	24 hrs.
Due to Uremia	5 yrs.
Due to Chronic Bronchitis	10 yrs.
Other Conditions ?	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury.
23. Signature Edward Zimmerman M. D.
Address 2858 Harford Road Date signed

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G24514 Neyhardt ✓ G24514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 721 S Caldwell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick Lybert (Neyhardt)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha Lybert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years 38 | Months | Days | If less than one day hr. min.

9. Birthplace Pa.

10. Usual Occupation Salesman.

11. Industry or business

FATHER
12. Name Frederick Lybert
13. Birthplace Pa.

MOTHER
14. Maiden Name Effie Williams
15. Birthplace Pa.

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/10/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Berwick Pa.

18 (a) Funeral director H. H. Hipsley
(b) Address 4646 Edmondson Ave.

19 JAN 10 1945 (Date rec'd by registrar) Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9 1945 at 10 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6-1944 to 1-9 1945 and that I last saw h alive on 1-9-1945

Immediate cause of death Debilitation, malnutition — Duration

Due to Lymphosarcoma — 6 mo

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurie Duckett M.D.
Address Johns Hopkins Hosp Date signed 1/9/45

VS 150

G24515

JL - 3224?

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 B

G24515

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Do not write in spaces RESERVED FOR BOOKING correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 6- 13

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3832 Kimble Road (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John Walz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Widowed

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1867

8. AGE: Years	Months	Days	If less than one day
77	2	8	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER

12. Name John Walz

13. Birthplace Germany

MOTHER

14. Maiden Name Christine Hermann

15. Birthplace Germany

16 (a) Informant B.C.H. Records

(b) Address 1940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 10 45 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location "

18 (a) Funeral director Philip Herwig Sons

(b) Address 2224 Orleans St

19 (a) JAN 10 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION 45

20. DATE OF DEATH Jan. 7, 19~~44~~ 45 at 1:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 24, 19~~44~~ 45 to Jan 7 45 19~~44~~, and that I last saw him alive on Jan. 7 19~~44~~.

Immediate cause of death: Heart failure — Duration: a few days

Due to: Pulmonary Tuberculosis — Duration: over 3 years.

Due to:

Other Conditions: Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Louis Edmunds M. D.

Address Baltimore City Hospitals Date signed 1-7-45

VS 150

(OVER)

G24516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 C

Registered No. G24516

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 N.Castle St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 N.Castle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Koehler Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Theresa Koehler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.10,1866

8. AGE: Years	Months	Days	If less than one day
78	2	28	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Henry Koehler
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Theresa Koehler
(b) Address 411 N.Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan.10/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto.Md.

18 (a) Funeral director Philip Hennig Sons
(b) Address 2024 Orleans St.

19 (a) JAN 10 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan.7/45 19 , at 2P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5, 19 38 to Jan. 7, 19 45, and that I last saw him alive on Jan. 6 19 45

	Duration
Immediate cause of death Coronary thrombosis	1 day
Myocardial insufficiency	
Due to Chronic valvular heart disease. ?	
Due to Arterio-sclerosis	20 yrs.
Other Conditions Chronic arthritis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature I. B. Bronushas, M. D.
Address 3037 O'Donnell St M. D.
Date signed 1-9-45

PLEASE WRITE PLAINLY, WITH UNFADABLE INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24517 X ✓ G24517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Essex
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 401 Marlyn ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph V. Weiningen (Joseph V. Weininger)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 705-05-5109

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28 1887

8. AGE: Years 57 | Months 0 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Trainman

11. Industry or business B & O R.R

FATHER
12. Name Adam J. Weininger
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Sheuin
15. Birthplace Germany

16 (a) Informant Mrs. Singleton
(b) Address 3311 Ravenswood Ave

17 (a) Burial (b) Date thereof 1-10-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory U. S. National
Location Baltimore

18 (a) Funeral director Phillip Weininger Son
(b) Address 2824 Oakenshawe

19 (a) JAN 10 1945 (b) Huntington Publishing Co.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6- 1945, at 11.52 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Crushed head.

Due to

Other Conditions Avulsion of brain tissue
Fractured right tibia & fibula etc.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-6-45 at 11.30 P M.
(b) Where did injury occur? Marlyn & Eastern Aves.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work?
(d) Means of injury Pedestrian, struck by automobile

23. Signature Howard J. Mackey M.D.
Medical Examiner.
Date signed 1-7-45

VS 151

G24518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G24518
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 777 Wash Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ginsberg, Nathan

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	Widow

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day hr.	min.
72				

9. Birthplace Lith.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Solomon
13. Birthplace Lith.

MOTHER
14. Maiden Name Freda
15. Birthplace Lith

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1432 E. Balto St.

19 (a) JAN 10 1945 Registrar Harrington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9 1945, at 11 50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1944, to 1-9 1945, and that I last saw him alive on 1-9 1945.

Immediate cause of death Cardiac failure — Duration

Due to Arteriosclerotic C-V Disease

Due to Myocardial infarct

Other Conditions UREMIA
Diabetes
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jerome Richard Perlin M. D.
Address Sinai Hospital Date signed 1-9-45

93d

624513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 32a

624513 ✓ Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2404 Annapolis Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5"
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2404 Annapolis Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Deellear P. Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife Peter Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1874

8. AGE: Years	Months	Days	If less than one day
70	5	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Welford Day
13. Birthplace Va.

MOTHER
14. Maiden Name Deellear Kelley
15. Birthplace Va.

16 (a) Informant Mrs. Edna Logan
(b) Address 2404 Annapolis Ave.

17 (a) Burial (b) Date thereof 1-12-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JAN 10 1945 (b)
(Date rec'd by registrar) Registrar

VE 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH 1-8-45 19 , at 3:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/3 1945, to 1/8 1945, and that I last saw h alive on 19

Immediate cause of death: Bronchial Pneumonia — Duration: 5

Due to: Recurrent Bronchitis

Due to: Influenzal type

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Bowley

Address 519 N Carrollton Date signed 1/8/45

G24530 G24530

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

108

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1009 Harlem Ave (St.) (Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 16 yrs. mos. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME ~~Robert~~ Elmer Clark

If U.S. Veteran specify WAR

(a) Residence: No. 1009 Harlem St. Ave Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Feb 15 1884

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	2	23	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Lab.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) (State or country) Md

FATHER

13. NAME Frank Clark

14. BIRTHPLACE (city or town) (State or country) Md

MOTHER

15. MAIDEN NAME Anna Frederick

16. BIRTHPLACE (city or town) (State or country) Md.

17. INFORMANT Mrs Edna Spencer

(Address) 1009 Harlem Ave.

18. BURIAL, CREMATION, OR REMOVAL

Place Abingdon, Md Date 1-11 19 45

19. UNDERTAKER Wm. Francis A. Hemsley

(Address) 548 W. Biddle St.

20. FILED 19

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan 8 1945

22. I HEREBY CERTIFY, That I attended deceased from Dec 30 1944 to Jan 8 1945

I last saw h alive on 19 Death is said to have occurred on the date stated above, at 7 A.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	

Other contributory causes of importance:

Was an operation performed? — Date of —

For what disease or injury? —

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Frank E. Wagner M. D.

(Address) 3027 Lealvert.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 10 1945 Hunting on Milano, Md

X

G24521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G24521 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 225 N. Carrollton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 N. Carrollton Av. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Garnett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, '76

8. AGE: Years	Months	Days	If less than one day
68	9	9	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Jacob Garnett
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Dodson
15. Birthplace Va.

16 (a) Informant Rev.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-11-45 (month) (day) (year)
(c) Cemetery or crematory Mt Zion Cem
Location Baltimore Md

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JAN 10 1945 (Date rec'd by registrar) Registrar, M.D.

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH 1-7-45 19 at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 19 45 to 1/7 19 45
and that I last saw h[illegible] alive on 1/7 19 45

Immediate cause of death
Due to Rt Lobar Pneumonia
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Calderone
Address 113 Harlem Ave Date signed 1/8/45

G21522 G21522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

MARG. RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1130 LAFAYETTE AVE
(c) Hospital or institution: NONE 16 W.
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town CITY BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 LAFAYETTE AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARY ELLEN BROWN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1865

8. AGE: Years 79 | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel Harris
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Harris
15. Birthplace Md.

16 (a) Informant Mr. Harry Brown
(b) Address 1212 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JAN 10 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH JANUARY 7 1945, at 4.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC 24 1944 to JAN. 7 1945, and that I last saw her alive on JAN 7 1945

Immediate cause of death: CHRONIC MYOCARDITIS DEC 24 — Duration: 1944
Due to: ARTERIOR SCLEROSIS — 1944
Due to: SENILITY — 1944
Other Conditions

(Include pregnancy within three months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. F. Blanton M. D.
Address 3013 ST PAUL ST JANUARY 7, 1945. Date signed

G24523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G24523

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 679 W. Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 679 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie Taylor

3 (b) If vetefan, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1848

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JAN 9 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 10 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1944, at 11:30 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio vascular - renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Jan 1st 1945

2458

G24524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G24524

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital - D.O.A
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3322 Resurrection Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Derr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
67		1	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name
13. Birthplace
MOTHER 14. Maiden Name
15. Birthplace
16 (a) Informant
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location
18 (a) Funeral director
(b) Address 1703
19 (a) JAN 10 1945 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2 1945, at 7:00 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy - Inquest thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Chester J. Lobrinke M.D. (Medical Examiner.)
Date signed 1/2/45

2437

VS 151

G24525

AB-13279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G24525

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not use abbreviations. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11yrs-3mos-8days

(e) Length of stay in Baltimore (yrs., mos., or days) 26yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 21 E. Center St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William Coddington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Ella (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct-1-1866

8. AGE: Years	Months	Days	If less than one day
78	3	8	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER

12. Name William A. Coddington

13. Birthplace Maryland

MOTHER

14. Maiden Name Rebecca Lee

15. Birthplace Pennsylvania

16 (a) Informant Baltimore City Hospitals (Records

(b) Address 4940 Eastern Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JAN 9 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 JAN 10 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 19 44, at 4 Am M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23 19 33 to 12-31 19 44, and that I last saw him alive on 12-31- 19 44.

Immediate cause of death Coronary Thrombosis — Duration 3

Due to

Due to

Other Conditions Hypertension Heart Disease — Duration 7

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Path

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address Balto, Md. Date signed 1-9-46

VS 150

2436

X

G24526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

180

Registered No. G24526

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 Myrtle ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Shirley Green

3 (b) If veteran, name war

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife –

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23 1944

8. AGE: Years	Months	Days	If less than one day
	7	13	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation –

11. Industry or business

FATHER
12. Name David Green
13. Birthplace Va

MOTHER
14. Maiden Name Lillie Muriel
15. Birthplace Va

16 (a) Informant Lillie Green
(b) Address 407 Myrtle ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 10, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St
(c) Katie R. Williams, Md

JAN 10 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6th 1945 at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to 3rd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-6-45 at 17/3 5:19 A.M.
(b) Where did injury occur? 407 Myrtle ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
Means of injury Conflagration

23. Signature Robert Lee Graham M.D. (Medical Examiner)
Date signed Jan 9 1945

VS 151

G21527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G21527 Registered No.

T.-90477

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos., 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 2039 E. Lombard Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Eva Bartels (EVA H. BARTELS)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1912

8. AGE: Years	Months	Days	If less than one day
32	8	19	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name James Cichocki (d)

13. Birthplace Poland

MOTHER

14. Maiden Name Helen Rachuba

15. Birthplace Poland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/45 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Baltimore

18 (a) Funeral director Fred W. Szczepanski

(b) Address 1930 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 10 1945

vs 180

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 1945, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1, 1944 to Jan. 8, 1945, and that I last saw her alive on Jan. 8, 1945

Immediate cause of death	Duration
Uremia	2
Due to chronic pyelonephritis	?
Due to	
Other Conditions hypertensive cardiovascular disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature C. E. Perry M.D.

Address City Hosp. Date signed 1/10/45

8

133a

G24528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G24528 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3820 Taylor Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3820 Taylor Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHRISTIAN J. DECKERT

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Bertha E. Deckert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 30, 1897

8. AGE: Years	Months	Days	If less than one day
47	0	8	hr. min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)
10. Usual Occupation Route Boss
11. Industry or business Dairy

FATHER
12. Name Fredk. J. Deckert
13. Birthplace Germany

MOTHER
14. Maiden Name Mary M. Krach
15. Birthplace Balto., Md.

16 (a) Informant Daughter
(b) Address 3820 Taylor Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Jan. 11, 1945 (month) (day) (year)
(c) Cemetery or crematory St. Johns Luth.
Location Parkville, Md.

18 (a) Funeral director Leander Funeral Home
(b) Address 7401 Belair Road

19 (a) JAN 10 1945 Huntington Williams Registrar
(b) Registered by

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8th 1945, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1942 to Jany 8 1945, and that I last saw him alive on Jany 7 1945

Immediate cause of death: Carcinoma Parotid Gland (Rt) — Duration Sept 2 1942

Due to

Due to

Other Conditions: Metastasis involving both Lungs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Morris B. Green M. D.
Address 3009 Eutaw Place Balto 14 Md Date signed 1/10/45

C21529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C21529 Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Fullerton (If outside city or town limits, write RURAL and give town)
(d) Street No. Box HH (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Margaret M. Kraft
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife George J. Kraft
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12/25/95

8. AGE: Years	Months	Days	If less than one day hr.	min.
59		14		

9. Birthplace Balto. Co. Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER 12. Name John Kremper
13. Birthplace Balto. Co. Md.
MOTHER 14. Maiden Name Mary Schafer
15. Birthplace Balto. Co. Md.

16 (a) Informant G. J. Kraft
(b) Address Fullerton P.O.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 13 45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Lazarus Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 10 1945 Hunting for Hillcrest, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9 1945 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4 1945 to 1-9 1945. and that I last saw her alive on 1-9 1945

Immediate cause of death Lobar Pneumonia — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M E Robertson M. D.
Address St Josephs Hosp Date signed 1-9 '45

G24530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G24530

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 939 Forrest St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 939 Forrest St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas W. Walsh

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War No 1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1897

8. AGE: Years	Months	Days	If less than one day
47	0	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Post Office

FATHER
12. Name John Walsh
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Casserly
15. Birthplace Ireland

16 (a) Informant Miss Jennie Giriel
(b) Address 939 Forrest St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore

18 (a) Funeral director Rita Wiederold
(b) Address 914 Greenmount Ave

19 JAN 10 1945 (b) (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 – 9 – 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 4 1945 to 1 7 1945 and that I last saw h im alive on 1 7 1945

Immediate cause of death Acute Coronary infarction — Duration

Due to Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Aisquith St Date signed 1/10/45

VS 150

G24531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G24531

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1130 Argyle Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 Argyle (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME Preamalee - Jackson

3 (b) If veteran, name war No
3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife No

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-6-46

8. AGE: Years | Months | Days | If less than one day 15 hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation No

11. Industry or business

FATHER 12. Name Wesley Jackson
13. Birthplace Balto. Md

MOTHER 14. Maiden Name Ruth Harris
15. Birthplace Balto Md

16 (a) Informant Evangeline Jackson
(b) Address 1130 Argyle

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JAN 9 1945

18 (a) Funeral director Commissioner of Health

(b) Address

JAN 10 1945 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7 1945 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6 1945 to 1-7 1945 and that I last saw h— alive on 1-6 1945

Immediate cause of death Pneumonia — Duration 15 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. M. Hatcher M. D.

Address 1205 Park Ave Date signed 1/7/45

2441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. G24532

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 743 Pine St
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 10 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 743 Pine (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sylvestia Burton twin #1

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race col | 6 (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife

6 (c) If alive, give age 10 hrs

7. Birth date of deceased (mo., day, yr.) 1/8/45

8. AGE: Years | Months | Days 10 hrs | If less than one day hr. min.

9. Birthplace 743 Pine St (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Llewellyn Burton
13. Birthplace Balto Md

MOTHER 14. Maiden Name Sarah V Hill
15. Birthplace Balto Md

16 (a) Informant Sarah V Burton
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JAN 9 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 10 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/8 1945 at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from during 1/8/45 to 19
and that I last saw h[illegible] alive on 1/8/45 19

Immediate cause of death Atelectasis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within three months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Williams M. D.
Address 11 S Harden Rd Date signed 1/8/45

VS 150

2440

G24533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. G24533

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARRIAGE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1942 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1942 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Newborn Burton Twin #2

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/8/45

8. AGE: Years | Months | Days | If less than one day hr. 1/2 min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Newborn Burton
13. Birthplace Balto, Md

MOTHER 14. Maiden Name Dorothy Hill
15. Birthplace Balto, Md

16 (a) Informant Sarah Burton
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.

UNIVERSITY MEDICAL SCHOOL JAN 9, 1945
Commissioner of Health

JAN 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/8/45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8/45 to 19 , and that I last saw h alive on 1/8/45 19 .

Immediate cause of death Atelectasis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hubbane
Address 1137 Hollins St Date signed 1/9/45

VS 150

2439

G24534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G24534

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1311 Marshall St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 Marshall St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida A. Martin

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widowed.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1870

8. AGE: Years 74 | Months 6 | Days 21 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John B. Martin
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Anna Crawford
15. Birthplace Baltimore Md.

16 (a) Informant Hazel Myers
(b) Address 1311 Marshall

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Road

18 (a) Funeral director Howard N. Bluff Jr
(b) Address 4914 Belair Road

19 (a) (Date received by local registrar) (b) [illegible] Registrar

JAN 10 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/8/45 at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 to 1/8/45.
and that I last saw it alive on 1/7/45

Immediate cause of death	Duration
Coronary thrombosis	2 hrs
Due to arteriosclerosis	
Due to	
Other Conditions Chronic nephritis (Include pregnancy within 3 months of death)	4 yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address 1111 Pleasant ST Date signed 1/9/45

C24535 | BALTIMORE CITY HEALTH DEPARTMENT | C24535

CERTIFICATE OF DEATH 93E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Loretta C. Massey

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	223-05-7305

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1889

8. AGE: Years	Months	Days	If less than one day
55	0	18	hr. min.

9. Birthplace Md. (Balto.)
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Lord Balto. Hotel

FATHER
12. Name John J. Massey
13. Birthplace Md. (Balto.)

MOTHER
14. Maiden Name Margaret Martin
15. Birthplace Md. (Balto).

16 (a) Informant Mr. Joseph Massey
(b) Address 3053 Gelston Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) JAN 10 1945 (b) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9 1945 at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/3 1945 to 1/9 1945 and that I last saw her alive on 1/9 1945.

Immediate cause of death Peritonitis — Duration

Due to Eroded tubo ovarian mass — Duration

Due to — Duration

Other Conditions Myocarditis — Duration per

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: —
of autopsy: Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard W Stier M. D.
Address St Agnes Hosp Date signed 1-9-45

X

G24536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G24536

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 705 E. 41st St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 E. 41st St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE H. MARKOLF

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lula E. Markolf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1874

8. AGE: Years	Months	Days	If less than one day
70	8	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Sheet Metal (ret'd. 2 yrs)
11. Industry or business Self

FATHER
12. Name Henry M. Markolf
13. Birthplace Germany

MOTHER
14. Maiden Name Rebecca List
15. Birthplace Germany

16 (a) Informant Mrs. Lula E. Markolf
(b) Address 705 E. 41st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Jan. 8, 1945, at 10:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1945, to 1-9 1945, and that I last saw h[illegible] alive on 1/8 1945.

Immediate cause of death	Duration
Acute Cardiac Dilatation	3 hrs
Due to Arteris sclerotic	?
Cardio vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony J. Thomas M. D.
Address 4600 Yorkrd Date signed 1/9/45

VS 150

JAN 10 1945 Hunting to Williams, M.D.

G24537 — 1938 — G24[illegible] Registered No.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St.
(c) Hospital or institution: Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Garrison Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MATILDA SHOWACRE

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Nelson C. Showacre
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1861

8. AGE: Years	Months	Days	If less than one day
83	11	24	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown Coleman
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Nelson E. Showacre
(b) Address 2212 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 10 1945

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Jan. 8, 1945, at 4:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1, 1944, to Jan. 8, 1945. and that I last saw h alive on 19

Immediate cause of death	Duration
Myocarditis	10 das.
Due to Advanced Arterio-sclerosis	??
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2210 Garrison Blvd. Date signed 1/9/45

G24538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

G24538 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4330 Roland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4330 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John B. H. Dunn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Jennie Fisk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/3/75

8. AGE: Years 69 | Months 5 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retail household supplies

11. Industry or business

FATHER
12. Name James F. Dunn
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Henderson
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Jennie F. Dunn
(b) Address 4330 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemy.
Location Pikesville, Md.

18 (a) Funeral director John D. Mitchell Sons Inc.
(b) Address 1900 Eutaw Place

JAN 10 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8, 1945, at 1:10 A.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/23/55 19 , to 1/8/ 19 45 and that I last saw him alive on 1/7/ 19 45

Immediate cause of death: Tuberculous meningitis. — Duration: 10 days.

Due to: Pulmonary tuberculosis. — 2 months.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin B. Jarrell.
Address 11 E. Chase St. Date signed 1/9/45

G21539

AB-91493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No. G21539

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 213 E. 21st. Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth or Rose Ritter

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1864

8. AGE: Years 80 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md.

10. Usual Occupation Unable to obtain information

11. Industry or business retired

FATHER
12. Name John B. Ritter
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Catherine Durin
15. Birthplace Balto. Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Jany 11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3804 Fredericks Ave.

18 (a) Funeral director John Mitchell Hoop
(b) Address 1900 Eutaw Place

19 (a) Jan 10 1945 Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Jan. 9- 1945 at 11.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-8- 1945 to 1-9 1945 and that I last saw her alive on 1-9 1945

Immediate cause of death Cardiac failure — Duration ?

Due to Arteriosclerotic heart disease — ?

Due to

Other Conditions ? Cerebro-vascular accident — ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Partial

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Emmett Lynch

Address Balt. City Hosp Date signed 1/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

RIGHT RESERVED FOR BINDING

G24540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G24540

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3730 Hickory Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3730 Hickory Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Florence Maria Parsons

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James Edward Parsons
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31-1871

8. AGE: Years 73 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace Frederick, Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Frank M. Stup
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna M. Grove
15. Birthplace Maryland

16 (a) Informant Miss Nellie L. Parsons
(b) Address 3730 Hickory Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 11-1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Maryland

18 (a) Funeral director Durgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) (Registrar)

VS 1a JAN 10 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9- 1945 at 7 50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 - 1945 to Jan 9 1945.
and that I last saw h.e alive on Jan 8 1945

Immediate cause of death Myocardial Infarction — Duration —
Due to Acute Coronary Thrombosis — Duration 4 dy
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature [signature]
Address 3429 Chestnut Ave Date signed 1/9/45 M. D.

X

G24541

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G24541 Registered No. 13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3628 Hickory Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3628 Hickory Avenue (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Charles William Bratman

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-03-6358

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna Evelyn Bratman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25-1922

8. AGE: Years 22 Months 11 Days 12 If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Cost Accountant

11. Industry or business Baltimore Mfg. Corp.

FATHER 12. Name Charles L. Bratman

13. Birthplace Maryland

MOTHER 14. Maiden Name Evelyn B. Fitez

15. Birthplace Maryland

16 (a) Informant Mrs. Evelyn B. Bratman

(b) Address 3628 Hickory Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 10-1945 (month) (day) (year)

(c) Cemetery or crematory Pipe Creek

Location Carroll Co. Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 (a) JAN 11 1945 (b) Hunter for William M.E. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7 1945 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1943 19 , to Jan 7 1945.
and that I last saw him alive on Jan. 7 1945.

Immediate cause of death active pulmonary Tuberculosis — Duration Two years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Wallenstein M. D.

Address 2848 N. 36th Date signed 1/3/45

VS 150

G24542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G24542 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 602 N. Carrollton av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 N. Carrollton ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Cothorn

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex male | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Easter Cothorn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858 1845

8. AGE: Years 87 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Middlesex Co. Va
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Thomas Cothorn

13. Birthplace Va

MOTHER 14. Maiden Name Lucy Harris

15. Birthplace Va

16 (a) Informant Bessie Clark

(b) Address 602 N. Carrollton ave

17 (a) Burial (b) Date thereof Jan 11-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Lebanon

Location

18 (a) Funeral director James A Hayes

(b) Address 142 Woods St

19 (a) (b)
(Date rec'd by registrar) Registrar

vs JAN 10 1945 Huntington Millcastle M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1945, at 10 a.m. M

21. I certify that death occurred on the date above stated, that I attended deceased from 1/4 1945 to 1/8 1945 and that I last saw him alive on 1/7 1945.

Immediate cause of death: Hemiplegia Cerebral Condition

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 3 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature H. J. Hatcher M.D.

Address 1775 Park Date signed 1/9/45

X

G24543

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 133B

G24543 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 36 Parkin St., Balto., Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Miss Catherine Cunningham

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1902

8. AGE: Years	Months	Days	If less than one day
42	7	18	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Secretary
11. Industry or business Mercy Hospt.

FATHER
12. Name John Cunningham
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Margaret A. Callan
15. Birthplace Baltimore, Maryland

16 (a) Informant Teresa Cunningham
(b) Address 835 N. Fulton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Road

18 (a) Funeral director John J. Conroy & Son
(b) Address 901-03 Hollins Street

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 10 1945
Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9 1945, at 1 18 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 4 1944 to Jan. 9 1945; and that I last saw h[illegible] alive on Jan 9 1945

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Cardiac Decompensation	
Due to	
Other Conditions Right nephrectomy (Include pregnancy within 3 months of death)	

Date of operation 1-3-45
Major findings of operation: Hydronephrosis, Hydroureter, Multiple abscess of Right kidney.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature T. R. Inglis M. D.
Address Mercy Hospital Date signed

X 1-9-45

G24544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G24544 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 743 Patterson Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Reisterstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Frances Virginia Tinkler

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John L. Tinkler
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 30 1860

8. AGE: Years 84 | Months 11 | Days 10 | If less than one day hr. min.

9. Birthplace Balto Co
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Emory Grant
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah F. Brown
15. Birthplace Md.

16 (a) Informant Geo. H. Vandusky
(b) Address 743 N Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13-45 (month) (day) (year)
(c) Cemetery or crematory Reisterstown Methodist
Location Reisterstown

18 (a) Funeral director J. F. Elmer Sons
(b) Address Reisterstown Md.

JAN 10 1945 (Date rec'd by Registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1945 1.05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 ; and that I last saw h alive on 19

Immediate cause of death

	Duration
Due to Cardiac Decay	2 days
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.

Address Date signed 1-9-45

G24545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G24545 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 329 E. Hamburg St. 24
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 329 E. Hamburg St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Bayline

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Joseph Bayline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24 1873

8. AGE: Years	Months	Days	If less than one day
71	9	13	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business GRENZER

FATHER
12. Name Charles Bayliss
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Brill
15. Birthplace Balto. Md.

16 (a) Informant Mr. Milton L. Bayline
(b) Address 329 E. Hamburg St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/45 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Edmondson Ave.

18 (a) Funeral director Fred. J. Kinsley & Son
(b) Address 1216 N. Charles St.

19 (a) (Date rec'd by registrar) JAN 10 1946 (b) Registrar Huntington Williams, M.D.

DS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7/45 19 at 2:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/4 1945 to 10/7 1945 and that I last saw h[illegible] alive on 10/7 1945

Immediate cause of death	Duration
Coronary thrombosis	3 days
Due to arteriosclerosis	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Isaac Miller M. D.
Address 1225 N. Charles St. Date signed X 10/8/45

G24546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G24546 Registered No.

Every item of information should be carefully supplied, and the causes of death clearly and legibly. Physicians: please write the correct age is especially important. PRINTED, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address S. S. Randall Pier 7
(c) Hospital or institution: So. Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Aliceanna St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WLADIMIR Karzpki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace RUSSIA.
(Town, county, and state)

10. Usual Occupation CARPENTER

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Unk.
15. Birthplace

16 (a) Informant
(b) Address

17 (a) BURIAL (b) Date thereof 1/11/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory SACRED HEART OF MARY
Location GERMAN HILL ROAD.

18 (a) Funeral director M. F. Sadowski & Son
(b) Address 1808 Eastern Ave.

19 (a) JAN 10 1945 (Date filed by registrar) Huntington Williams Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 — 8 1945, at 6 15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions Fell down hold of ship

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 24/1 Locust Point
(a) Date of injury 1-8-45 at P.M.
(b) Where did injury occur? S. S. Randall Pier 7
(c) Did injury occur at home, on farm, industrial place, in public place? Aboard ship While at work? YES
(d) Means of injury. Accidental fall

23. Signature. Edward E. Miller M.D.
Medical Examiner.
Date signed 1-9-45

VS 151

G24547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓83a

Registered No. G24547

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 734 W Franklin
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 734 W Franklin (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Wheatley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May - 1895

8. AGE: Years	Months	Days	If less than one day
50	8		hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation B. & O. Railroad
11. Industry or business

FATHER
12. Name William Wheatley.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Louisa Palmer.
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mary Spriggs
(b) Address 734 W. Franklin St.

17 (a) Burial (Buried, cremation, or removal) (b) Date thereof Jan. 10 '45 (Month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Katie R. Williams
(b) Address 322 N. Schroeder St.

JAN 10 1945 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 1945 at 7.40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945 to Jan 6 1945 and that I last saw h[illegible] alive on Jan 5 1945

Immediate cause of death Cerebral hemorrhage — Duration 4 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 734 W Franklin Date signed Jan 10 1945

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G24548

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
Since 1/7/45
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Del. (b) County:
(c) City or town: Dover (If outside city or town limits, write RURAL and give town)
(d) Street No.: Wyoming Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME WM. CHARLES SCHWARTZ

3 (b) If veteran, name war: -

3 (c) Social Security Account No. 222-10-5532

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife: Elizabeth ?

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6/3/1884

8. AGE: Years: 60 | Months: 7 | Days: 5 | If less than one day: hr. min.

9. Birthplace: Detroit. Michigan (Town, county, and state)

10. Usual Occupation: Oiler

11. Industry or business: Merchant Marine

FATHER
12. Name: Jos. Schwartz
13. Birthplace: Germany

MOTHER
14. Maiden Name: Minnie Broderdorp
15. Birthplace: Germany

16 (a) Informant: Records U.S.Marine Hosp.
(b) Address: Baltimore, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/10/45 (month) (day) (year)
(c) Cemetery or crematory
Location: Wilmington, Del.

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: North & Pa. Aves.

19 (a) (Date rec'd by registrar) (b)

JAN 10 1945 Huntington for Williamsville

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH: Jan. 8, 1945 at 9:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7, 1945 to Jan. 8, 1945, and that I last saw him alive on Jan. 8, 1945.

Immediate cause of death: Coronary thrombosis — Duration: Just prior to death

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: [signature] M. D.

Address: Baltimore, Md. Date signed: 1/9/45

MS-58101

G24549

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G24549 Registered No.

Every item of information should be carefully supplied. Be sure that the causes of death clearly and legibly. Physicians: please write the correct age is especially important. PRINT IN LONG INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Cane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Widowed

6 (b) Name of husband or wife Roretta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 - -188?

8. AGE: Years	Months	Days	If less than one day
60	10	-	hr. min.

9. Birthplace Eastern Shore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Nellie Hill
(b) Address 512 McMechen St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director Wm. A. Jackson
(b) Address 916 Penna Ave.

19 (a) JAN 10 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 5 - 1945, at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions Pulmonary Edema

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Edward E. Miller M.D. Medical Examiner.
Date Signed 1-6-45

VS 151

C24550 C24550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 W. Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stephen Whirley

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/4/1878

8. AGE: Years	Months	Days	If less than one day
66	6	5	hr. min.

9. Birthplace (S.T) Charles City Co., Va (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name ?
13. Birthplace Va.

MOTHER
14. Maiden Name Patsey Whirley
15. Birthplace Va.

16 (a) Informant John Whirley
(b) Address 1314 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Charles City Co., Va.

18 (a) Funeral director Charles R. Lowe
(b) Address 802 Madison Ave.

19 (a) (Date received by Registrar) (b) Huntington Williams Registrar

JAN 10 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/9 1945 at 5:50 A.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Eugene B. Mitchell M.D. Medical Examiner.

Date signed 1/9/45

correct age is especially important. Physicians: please write the c

G24551 BALTIMORE CITY HEALTH DEPARTMENT G24551
Registered No.

CERTIFICATE OF DEATH 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 Ryan st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 917 Ryan st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella E. Willis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1. 1939

8. AGE: Years 5 | Months 1 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew J. Willis
13. Birthplace Carroll Co Va.

MOTHER
14. Maiden Name Mary Busley
15. Birthplace Carroll Co Va.

16 (a) Informant Andrew Willis
(b) Address 917 Ryan st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/44 (month) (day) (year)

(c) Cemetery or crematory Meadow ridge
Location Washington Blvd

18 (a) Funeral director Arthur Rose Inc.
(b) Address 414 N Franklintown Rd

19 JAN 10 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 1945, at 6 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1945 to Jan 9, 1945 and that I last saw her alive on Jan 7, 1945

Immediate cause of death / Bronchopneumonia — Duration 3 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J Lapp M. D.
Address 876 Warlington Ave Date signed Jan 10, 1945

VS 150

G24552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160c

Registered No. G24552

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2200 Lanvale Ave
(c) Hospital or institution: Wm Balto Gen Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 9 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 Nicoll Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Strobeiter

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day 9 hr. min.

9. Birthplace W. Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Strobeiter
13. Birthplace Balt. Md.

MOTHER 14. Maiden Name Elizabeth Fischer
15. Birthplace Balto Md

16 (a) Informant Joseph Strobeiter
(b) Address 602 Nicoll Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/45 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Homelands Jr

18 (a) Funeral director Lindo DeLeon Sons
(b) Address 131 E Biddle St

19 (a) JAN 10 1945 (Date rec'd by registrar) (b) Waterington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1945, at 2.35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7 1945 to 1/8 1945, and that I last saw him alive on 1/7 1945.

Immediate cause of death Cardio-Respiratory Failure — Duration

Due to Prematurity

Due to

Other Conditions Cesarean Section - Premature Separation of low implanted placenta
(Include pregnancy within 3 months of death)

Date of operation 1/7/45

Major findings of operation: Premature Separation of Low implantation of placenta

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward C. Way M.D.

Address 608 Bolton Ave Balto Gen Hosp Date signed 1/8/45 M. D.

X

G24553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G24553

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1501 N. Madeira St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 N. Madeira St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Luther A. Clayton

3 (b) If veteran, name war

3 (c) Social Security Account No. 719-09-2919

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ruby G. Clayton

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Feb 13-1884

8. AGE: Years 60 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Woodstock Georgia (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Edgewood Dairy

FATHER 12. Name Madison A. Clayton

13. Birthplace Georgia

MOTHER 14. Maiden Name Anna Cobert

15. Birthplace Georgia

16 (a) Informant Ruby G. Clayton

(b) Address 1501 N. Madeira st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-45 (month) (day) (year)

(c) Cemetery or crematory Shiloh Cem.

Location Holly Springs Georgia

18 (a) Funeral director John E. Miller Inc

(b) Address 2435 E Oliver St

19 (a) (Date rec'd by Registrar) 1-10-45 Interment Willow Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24, 1944 to Jan. 9, 1945 and that I last saw him alive on Jan. 9, 1945.

	Duration
Immediate cause of death: Acute Cardiac Dilatation.	12 hrs
Due to: Chronic Myocarditis	6 Mos.
Due to:	
Other Conditions: Bronchial Asthma.	5 yrs.

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. E. Simonds M. D.

Address 613 E. North Ave. Date signed 1-10-45

G24554 BALTIMORE CITY HEALTH DEPARTMENT G24554
CERTIFICATE OF DEATH
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dr.Becks Home
(c) Hospital or institution: St.Paul & 23rd Streets
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.County
(c) City or town Gray Manor (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Amanda M.Lueck

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Henry Lueck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-1-1889

8. AGE: Years	Months	Days	If less than one day
55	2	8	hr. min.

9. Birthplace Main Wisconsin (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Albert Plautz
13. Birthplace Hamburg Wis.

MOTHER
14. Maiden Name Louise Radeuntzel
15. Birthplace Germany

16 (a) Informant Rev.Orville Lueck
(b) Address Gray Mannor Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-11-45 (month) (day) (year)
(c) Cemetery or crematory Shipped to
Location Wausau Wisconsin

18 (a) Funeral director Albert L Hilt
(b) Address 1606 N.Chester Street

(b) Huntington Williams, M.D.

JAN 10 1945 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1945, at 10 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1944 to Jan 9 1945, and that I last saw h alive on Jan 9 1945.

Immediate cause of death Congestive Heart Failure — Duration 2 days

Due to Carcinoma of Lung (Pleura & Lung) — 2

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Haddeus S Black M. D.
Address 100 E 23d St. Date signed

G24555 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G24555

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 W. Fayette ST.
(c) Hospital or institution: Bon Secours Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 1/2 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 20 1/2 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 839 Franklintown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Nason

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-9-45- 2:32 PM

8. AGE: Years | Months | Days | If less than one day: 20 1/2 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Daniel Dwight Nason
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ethel May Fletcher
15. Birthplace Baltimore Md.

16 (a) Informant ETHEL-M. NASON
(b) Address 839 FRANKLINTOWN-ROAD

17 (a) BURIAL (b) Date thereof JAN-10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory WESTERN
Location BALTO, MD.

18 (a) Funeral director F. B. WIPPERT. SON
(b) Address BALTO-& MONROE STS

19 (a) JAN 10 1945 (b)
(Date received by Registrar) Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/9 1945, at 11:9AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8 1945 to 1/9 1945 and that I last saw h[illegible] alive on 1/9 1945

Immediate cause of death: Congenital atelectasis — Duration: 24 hrs
Due to: Incomplete development of organs
Due to: Prematurity

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. F. L. Michel M. D.
Address Bon Secours Hosp. Date signed 1/9/45

G24556

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G24556 / 107

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2103 Penn Street
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Lindy Stokes

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Child

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 5, 1944

8. AGE: Years	Months	Days	If less than one day
	1	4	..... hr. ..... min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name Henry Stokes
13. Birthplace South Carolina

MOTHER
14. Maiden Name Josephine Davis
15. Birthplace South Carolina

16 (a) Informant Henry Stokes
(b) Address 210 Penn Street

17 (a) Burial (b) Date thereof Jan 13, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mount Lebanon
Location Baltimore County Md

18 (a) Funeral director Joseph J. Lively
Address 410 N Mount Street

19 (a) JAN 10 1945 (b) .....
(Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 1945, at 11 25 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH .....
Bronchial Pneumonia

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Leonard E. Miller M.D.
Medical Examiner.
Date signed 1-9-45

Every item of information should be carefully supplied. Where a change, even in correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G24557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

G24557
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 E 23rd St.
(c) Hospital or institution: Beck Diagnostic Clinic
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 St. Dunstans Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL JOHN CONNOR, Jr.

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Mary Virginia Connor
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1862

8. AGE: Years 83 | Months — | Days 7 | If less than one day — hr. — min.

9. Birthplace Baltimor Md
(Town, county, and state)

10. Usual Occupation Letter Carrier ret. 13 yrs
11. Industry or business

FATHER
12. Name Michael John Connor
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Mary Jane Monk
15. Birthplace Hanford Co Md

16 (a) Informant Mrs. Edward W. Smith
(b) Address 206 St Dunstin Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-11-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Cemetery
Location Baltimore, Md.

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) 1945 (b) Rec'd by registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1945, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 28 1944 to Jan 8 1945, and that I last saw him alive on Jan 8 1945.

Immediate cause of death: Congestive Heart failure — Duration 2 days
Due to: Arteriosclerosis — 2
Due to: Chronic Nephritis (2) & Uremia (2 weeks.)
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harvey H Beck M. D.
Address 100 E 23d St. Date signed Jan 8/45

Harvey H. Beck

G21558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G21558

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 S.CHAPEL ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 S.CHAPEL ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: JOSEPH W.TRACY

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife JANE TRACY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR.22 1877

8. AGE: Years	Months	Days	If less than one day
67	8	17	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation ELEVATOR OPERATOR
11. Industry or business AMERICAN CAN.CO.

FATHER
12. Name JOHN TRACY
13. Birthplace BALTO.MD.

MOTHER
14. Maiden Name MARY JOHNSON
15. Birthplace BALTO.MD.

16 (a) Informant JANE TRACY (WIFE)
(b) Address 514 S.CHAPEL ST.

17 (a) BURIAL (b) Date thereof JAN.11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT.CARMEL
Location ODONELL ST.

18 (a) Funeral director Lilly & John Co.
(b) Address 403 S.WOLFE ST.

19 (a) [illegible] Huntington Williams, M.D.
(Registrar) Registrar

JAN 10 1945

VS 150

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH JAN. 8 1945 at 2/30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1943 to Jan. 8 1945, and that I last saw h[illegible] alive on Jan. 8 1945

Immediate cause of death	Duration
Myocardial Insufficiency	7 days
Due to Mitral Regurgitation	3 yrs.
Due to Chronic Myocarditis	4 yrs.
Other Conditions Cardiac Asthma	2 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John V. Kapsbrahin
Address 9802 Easter Ln Date signed 1-9-45 M. D.

G24559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

G24559
Registered No.

Every item of information should be carefully supplied; write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Eastern Ave. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME James G. Budzynski (Cross)

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15th, '02

8. AGE: Years	Months	Days	If less than one day
42	4	24	....hr. ....min.

9. Birthplace Baltimore, Maryland. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Andrew Budzynski
13. Birthplace Poland

MOTHER
14. Maiden Name Josephine Nowakoushi
15. Birthplace Poland

16. (a) Informant Vera Mack, (sister)
(b) Address 1908 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Po. Nat.
Location German Hill Road

18 (a) Funeral director Lilly Zirkin Inc.
(b) Address 403 S. Wolfe Street

19 (a) (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8th 1945, at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide,

Due to 2nd degree burns

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 2/1
(a) Date of injury January 8, 1945 M.
(b) Where did injury occur? 1908 Eastern Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Conflagration

23. Signature Robert D. Stitzer M.D. Medical Examiner.
Date signed Jan 9 1945

VS-161

G24560 BALTIMORE CITY HEALTH DEPARTMENT G24560

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2815 Ailsa ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 Ailsa ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME May B Fuhrman Greenholt

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	widow

6 (b) Name of husband or wife George W Greenholt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27-1866

8. AGE: Years	Months	Days	If less than one day
78	7	12	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Edward Fuhrman
13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Warner
15. Birthplace Md

16 (a) Informant Miss Helen Greenholt
(b) Address 2815 Ailsa ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 12/45 (month) (day) (year)
(c) Cemetery or crematory Manchester Md
Location Arnold Md

18 (a) Funeral director Edw S Tipton
(b) Address Hampstead Md

19 (a) JAN 10 1945 (Date rec'd by local registrar) Huntington Williamsport, Md. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9, 1945 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12, 1944 to Jan. 9, 1945 and that I last saw her alive on Jan. 8, 1945

Immediate cause of death	Duration
Coronary occlusion and Chronic Myocarditis	2 yrs
Due to Arteriosclerosis	8 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas G Swingwald M. D.
Address 613 E. North Ave Date signed 1-9-45

G24561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24561 Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 426 N. Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 426 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Lucie Hayes

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9 1883

8. AGE: Years 61 Months 6 Days 29 If less than one day hr. min.

9. Birthplace Gloucester Co. Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Peter Grevious
13. Birthplace Va

MOTHER
14. Maiden Name Jane Carter
15. Birthplace Gloucester Co. Va

16 (a) Informant Florence V. Johnson
(b) Address 9 E. 129th St New York.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-45 (month) (day) (year)
(c) Cemetery or crematory Emory Church
Location Mathews Co. Va.

18 (a) Funeral director Mrs Lee H. Hallowell
(b) Address 1631 Druid Hill Ave.

19 (a) JAN 10 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1945, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to Jan 8 1945 and that I last saw him alive on Jan 8 1945.

Immediate cause of death Lobar pneumonia — Duration 7 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Watts

Address 515 Lexington Date signed 1/10/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45c

G24562 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 6/26/44-11:30 A.M.
(e) Length of stay in Baltimore (yrs., mos., or days) Since past 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ---

3 (a) **FULL NAME** VICTOR CARLTON TRAVERS

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex White Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife Lillian Dunn
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1880

8. AGE: Years	Months	Days	If less than one day
64	10	4	hr. min.

9. Birthplace Taylors Island, Md.
(Town, county, and state)
10. Usual Occupation Fisherman
11. Industry or business -

FATHER
12. Name Samuel C. Travers
13. Birthplace West Indies

MOTHER
14. Maiden Name Susie Gould
15. Birthplace Carroll Co., Md.

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. O. Mears and Son
(b) Address 805 N. Calvert Street

19 JAN 10 1945 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Jan. 10, 1945, at 9:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26, 1944, to Jan. 10, 1945, and that I last saw him alive on Jan. 10, 1945.

Immediate cause of death Squamous cell carcinoma of mucous membrane of mouth with metastases — Duration Since early 1938

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None done
Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank J. Edwards, M.D.
Address Baltimore, Md. Date signed 1/10/45

VS 150

NCA-53789 J. F. VAN ACKEREN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G24563

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1617 John St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 John St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM JOHN DONNELLY

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Amelia E. Donnelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1875

8. AGE: Years	Months	Days	If less than one day
69	2	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Storekeeper
11. Industry or business Self

FATHER
12. Name William Charles Donnelly
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Jennie Geddes
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Amelia E. Donnelly
(b) Address 1617 John St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 11 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8, 1945, at 3:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1945 to Jan 8/1945, and that I last saw h[illegible] alive on Jan 7/1945

I. Principal cause of death — Duration
Cerebral hemorrhage — 1 hr.
Hypertension Congestive heart failure — 2 days
Due to Pneumonia, Bilateral — 4 days
Due to (Paralysis agitans)

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. K. Houck MD
Address 1527 W Mont Ave Date signed 1/10/1945

VS 150

X

G24564 ✓ G24564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 201 Cold Spring Lane
(c) ~~Hospital or~~ institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 4307 Stanwood Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Webster Parsons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Lillian C. Parsons
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Nov 15th 1872

8. AGE: Years	Months	Days	If less than one day
72	1	24	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Salesman

FATHER
12. Name Wesley W. Parsons
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Jane Anderson
15. Birthplace Balto Md.

16 (a) Informant Theodora Sladky
(b) Address 4139 Mary Ave

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 1/11/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto Md

18 (a) Funeral director William Crook Jr.
(b) Address 257 St Paul St

19 (a) (Date rec'd by registrar) (b) Huntington Wilkinson Registrar

VS 150 JAN 11 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9th 1945 at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1944, to Jan 9 1945, and that I last saw him alive on Jan 5 1945.

Immediate cause of death	Duration
cerebral hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. N. Futterman M. D.
Address 2324 Auchentoroly Rd Date signed 1/9/45

X

G24555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G24555 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 Cator Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Cator Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Upshur Spencer

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Panola M. Spencer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30, 1882

8. AGE: Years	Months	Days	If less than one day
62	2	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Bailiff

11. Industry or business

FATHER
12. Name Allen D. Spencer
13. Birthplace Kentucky

MOTHER
14. Maiden Name Sarah P. King
15. Birthplace Md.

16 (a) Informant Mrs. Panola M. Spencer
(b) Address 702 Cator Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 12, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director G Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) JAN 11 1945 (Date rec'd by registrar) Registrar Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9, 1945 at 9.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1940, to Jan 9, 1945, and that I last saw him alive on June 9, 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: Dec 24 1944

Due to: Hypertensive cardio-vascular disease — Duration: years

Due to — Duration:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony J Thomas M. D.
Address 4600 York Rd Date signed 1/11/45

VS 150

G24366 ✓ G24366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 N Lexington St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Brengle, Mrs. Virgie

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband ~~or wife~~ Brengle, Mr. ?
dead
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 2, 1882

8. AGE: Years	Months	Days	If less than one day
62	2	3	..... hr. ..... min.

9. Birthplace Frederick, Md
(Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business Home

FATHER
12. Name William H. Waye
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Hart
15. Birthplace Md

16 (a) Informant Father H. N. O'Connor
(b) Address 222 N. Carrollton Ave

17 (a) Burial (b) Date thereof Jany 12 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Gwynns Oak Ave

18 (a) Funeral director J. W. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) ..... (b) .....
(Date received by registrar) Eva Williams M.D.
JAN 11 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1945 at 3:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-9 1945 to 1-10 1945, and that I last saw her alive on 1-10 1945.

Immediate cause of death Cardiac insufficiency — Duration 2 weeks
Due to Arteriosclerotic Heart Disease — yrs
Due to —
Other Conditions Adenocarcinoma 1st breast with extensive metastasis
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... (Specify type of place) While at work? .....
(e) Means of injury —

23. Signature Marvin W. Davis
Address Church Home Date signed 1-10-45 M. D.

93d

G24557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24557 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1103 N. EDEN ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 N. EDEN ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DOROTHY GILBERT

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife CHARLES E. GILBERT
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 1879

8. AGE: Years 65 | Months 2 | Days - | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation invalid
11. Industry or business

FATHER
12. Name GALION
13. Birthplace MD.

MOTHER
14. Maiden Name JOSEPHINE V. HALL
15. Birthplace MD.

16 (a) Informant WALTER R. WELDEN
(b) Address 1302 LONGWOOD ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JANY 11.1945 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN CEMETERY
Location GWYNN OAK AVE.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 900 EUTAW PLACE

19 (a) (Date rec'd by registrar) (b) Registrar

VS No. JAN 11 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH JANY . 8 . 1945 19 , at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1942 to 1/8 1945 and that I last saw h alive on Jan 8 1945

Immediate cause of death: Congestive Heart Failure — Duration
Due to Arteriosclerotic CVHD
Due to
Other Conditions Chr. Nephritis & Hypertension
Right hemiplegia - old - Cerebral hemorrhage
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Willard Applefeld M.D.
Address 2911 REISTERSTOWN ROAD Date signed 1/10/45

Burlington Publishing Co., Phila., Pa.

G21568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

Registered No. G21568

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 Cathedral Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Rural (Stevenson)
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Adgate Duer

3 (b) If veteran, name war: First World War
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife: Ellen Robinson Duer
6 (c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): Sept. 5, 1885

8. AGE: Years 59 | Months 4 | Days 4 | If less than one day: hr. min.

9. Birthplace: Baltimore County, Md. (Town, county, and state)
10. Usual Occupation: Pres. Barton Duer-Koch Paper Co
11. Industry or business: Wholesale Paper

FATHER
12. Name: Andrew Adgate Duer
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Margaret Lewis Marshall
15. Birthplace: Frederick County, Virginia

16 (a) Informant: Carlyle Barton
(b) Address: Baltimore Life Bldg. Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 11 1945 (month) (day) (year)
(c) Cemetery or crematory: St Thomas
Location: Garrison Forest

18 (a) Funeral director: Henry P. Kerkam & Sons
(b) Address: McCulloh & Orchard, Balto

19 (a) JAN 11 1945 (Date received by local registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 9 1945, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to ..... 19..., and that I last saw him alive on Jan 9 1945.

Immediate cause of death: Cerebral Embolism — Duration:
Due to:
Due to:
Other Conditions: Chronic Infections Arthritis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Walter A Bacher M. D.
Address: 1615 ~~E~~ Eutaw St Date signed: 6/10/45

G24569 ✓ G24569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1115 Poplar-Grove St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ***
(c) City or town Balto. 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Poplar-Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary G. Colquitt

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Wht.	Married

6 (b) Name of husband or wife Walter D. Colquitt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1873

8. AGE: Years	Months	Days	If less than one day
71	4	8	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation House-wife
11. Industry or business

FATHER
12. Name Arthur Jackson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sadie Jones
15. Birthplace Balto. Md.

16 (a) Informant Walter D. Colquitt
(b) Address 1115 Poplar-Grove St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Jan. 13, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) (b)

JAN 11 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1945 3.40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1944 to Jan 10th 1945 and that I last saw her alive on Jan 10 1945.

Immediate cause of death Coronary thrombosis — Duration 12 hours

Due to chronic myocardial disease with cardiac hypertrophy & congestive failure and hypertension — several years

Due to generalized arteriosclerosis — years

Other Conditions Diabetes mellitus. — 10 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Michels M. D.
Address 2901 Edmondson Ave Date signed Jan 10 45

93d

G21.0 ✓ G21.0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every item correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 A

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2855 W. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2855 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Annie E. Schroeder.

3 (b) If veteran, name war .....
3 (c) Social Security Account No. 216-16-9260

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Richard D. Schroeder
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 6. 1889

8. AGE: Years	Months	Days	If less than one day
55	11	4	hr. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Candy Packer,
11. Industry or business Martha Washington

FATHER
12. Name Clayton Brown,
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Cook,
15. Birthplace Md.

16 (a) Informant Richard D. Schroeder,
(b) Address 2855 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof ~~Jan.~~ Jan. 13. 1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore Co. Md.

18 (a) Funeral director George W. Little,
(b) Address 2700 Edmondson Ave.

19 (a) JAN 11 1945 (Date rec'd by registrar) (b) Huntington Woods

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10. 1945 19 ..., at 6.20 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1944 to Jan 10 1945, and that I last saw h[illegible] alive on Jan 10 1945.

Immediate cause of death Cerebral Hemorrhage Hemiplegia — Duration 3 days

Due to Arteriosclerosis. Hypertension Chronic Endocarditis Myocardial Deg. — Duration several years

Due to Chronic pyelonephritis nephritis — Duration years

Other Conditions .....

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature W. Michel M. D.
Address 790 Edmondson Ave Date signed Jan 10 45

X

G24571 ✓ G24571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 925 Pierce St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Octavia Moore

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colored	Widow

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
57			..... hr. ..... min.

9. Birthplace Virginia (town, county, and state)
10. Usual Occupation .....
11. Industry or business

FATHER
12. Name Gundil Jones
13. Birthplace Virginia

MOTHER
14. Maiden Name Minnie
15. Birthplace .....

16 (a) Informant .....
(b) Address .....

17 (a) Burial (b) Date thereof 1-13-40
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto., Md.

18 (a) Funeral director Jarmon & Taylor
(b) Address 1102 W. Pratt St

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10 1940 at 7:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon (Autopsy, Inspection or Inquest) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ——— at ——— M.
(b) Where did injury occur? ———
(c) Did injury occur at home, on farm, industrial place, in public place? ——— While at work? ———
(d) Means of injury .....

23. Signature Chester F. Lubansky M.D.
Medical Examiner.
Date signed 1/10/40

JAN 1 1943

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G21572

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1607 McKean Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 McKean Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: WILLIAM T. PULLER

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary E. Puller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1870

8. AGE: Years 74 | Months 5 | Days 23 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Retired Carpenter

11. Industry or business

FATHER
12. Name John Puller
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Soles
15. Birthplace Va.

16 (a) Informant Mr. Hubert G. Puller
(b) Address 1607 McKean Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/11/45 (month) (day) (year)
(c) Cemetery or crematory Bellamy Church Cem.
Location Gloucester County, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 11 1945 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10, 1945 at 5:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 23 1944 to Jan 10 1945 and that I last saw h[illegible] alive on Jan 10 1945

Immediate cause of death: Cerebral Hemorrhage — Duration: 17 days
Due to: Uremia — 5 days
Due to:
Other Conditions: Chronic Myocarditis — Unknown
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Cashman M.D.
Address 1925 Wroth Ave. Date signed 1/11/45

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 021543

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CALVERT STS.
(c) Hospital or institution:
ONION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 59 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE #16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2924 W. NORTH AVE.
(If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME CLEVELAND WORTHINGTON BATEMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED.

6 (b) Name of ~~husband~~ or wife Elizabeth C. BATEMAN.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) MARCH 3, 1885

8. AGE: Years 59 | Months 10 | Days 6 | If less than one day — hr. — min.

9. Birthplace Balto., MARYLAND.
(Town, county, and state)

10. Usual Occupation TRANSPORTATION CLERK

11. Industry or business WESTERN MD. R.R.

FATHER
12. Name JOSHUA BATEMAN
13. Birthplace MD.

MOTHER
14. Maiden Name HANNA M. CREAMER
15. Birthplace MD.

16 (a) Informant WIFE MRS. C. W. BATEMAN
(b) Address 2924 W. NORTH AVE. CITY 16.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/45 (month) (day) (year)
(c) Cemetery or crematory Carrollton Church of God Cem.
Location Carroll Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 1 1945 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9- 1945, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27- 1944 to 1-9- 1945, and that I last saw h[illegible] alive on JAN. 9 1945.

	Duration
Immediate cause of death CARDIO-RESP. FAILURE	1 HR.
Due to PNEUMONIA	2 days
Due to ARTERIOSCLEROSIS	10 yrs.
Other Conditions DIABETES GLOMERULONEPHRITIS	10 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D. Morris, M.D.
M. D.
Address [illegible] Date signed 1-9-45

2 97 on 130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

G24574 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 649 Bartlett Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 649 Bartlett Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Fahrman Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
57 06	—	—	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business Police Officer

FATHER
12. Name Wm A Fahrman
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Zahm
15. Birthplace Baltimore Md

16 (a) Informant Mrs Anna Fahrman
(b) Address 649 Bartlett Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 12-1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Mary M. Wedefeld
(b) Address 501 E. 22nd St

19 (c) JAN 11 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1945 at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to Jan 8 1945, and that I last saw h[illegible] alive on Jan 3 1945.

Immediate cause of death	Duration
Cardiac Failure	Unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence D. Lewis

Address 11 E. Chase St Date signed 1/11/45

G24573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G24573

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3816 Chatham Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3816 Chatham Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Caperon Hyman

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife ---

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1878

8. AGE: Years	Months	Days	If less than one day
66	4	24	hr. min.

9. Birthplace Amherst Co. Virgina (Town, county, and state)

10. Usual Occupation Stone Mason

11. Industry or business

FATHER
12. Name William Preston Hyman
13. Birthplace Pittsylvania Co. Va.

MOTHER
14. Maiden Name Mattie Susan Pendleton
15. Birthplace Amherst Co. Va.

16 (a) Informant Attie Buckner Irby
(b) Address #816 Chatham Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 13, 1945 (month) (day) (year)
(c) Cemetery or crematory Fairview Cem.
Location Roanoke Virginia

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave.

19 (a) ... (b) ...
(Date rec'd by registrar) JAN 11 1945 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10th 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26th 1944, to Jan. 10th 1945, and that I last saw him alive on Jan. 8 1945.

Immediate cause of death	Duration
1) Cerebral Sclerosis	5 yrs.
Heart Disease	
Due to	
Due to	
Other Conditions - Hypertension, Chronic Infected Prostate	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 410 Liberty Hgts. Ave. Date signed Jan. 11, 1945

X

G24576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G24576 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 Hollins Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles T. Hickman.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Ida M. Hickman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2nd 1861

8. AGE: Years	Months	Days	If less than one day
83	3	8	hr. min.

9. Birthplace Pondsmith, Md.
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Charles Hickman
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mrs Geo. W. Hickman
(b) Address 946 E. Ocean View Ave Norfolk Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/45 (month) (day) (year)

(c) Cemetery or crematory Forest Lawn Cem.
Location Norfolk, Va.

18 (a) Funeral director John Gordon & Son
(b) Address 901-03 Hollins Street

19 (a) JAN 11 1945 (Date rec'd by registrar) Hardie T. Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-10- 1945 at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madsen M.D.
Medical Examiner.
Date signed 1-10-45

G24577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G24577 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 129 N. High St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 129 N. High St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Barron

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Abraham Barron

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 75 Months Days If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Gabriel Farber

FATHER 13. Birthplace Russia

MOTHER 14. Maiden Name Vena -

MOTHER 15. Birthplace Russia

16 (a) Informant Abraham Barron

(b) Address 129 N. High St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12-45 (month) (day) (year)

(c) Cemetery or crematory Bnai Israel Cem.

Location Southern Ave.

18 (a) Funeral director Jos. Lewis & Bro

(b) Address 1439 E. Balto. St

19 JAN 11 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11-45 19 , at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1930 to 1/11 1945, and that I last saw her alive on 1/10 — 1945.

Immediate cause of death	Duration
Coronary occlusion thrombosis	
Due to Arterio-sclerosis	25 yr.
Due to	
Other Conditions Chr. Bronchitis Emphysema	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jacob Cohen M. D.

Address 1804 Eutaw Place Date signed 1/11/45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

~~21578~~ 1700 Registered No. G21578

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2916 Cheeley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Arthur Schwartz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mildred
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation Chiropractor
11. Industry or business

FATHER
12. Name Ignatz
13. Birthplace Hungary

MOTHER
14. Maiden Name Rose Schoen
15. Birthplace Hungary

16 (a) Informant
(b) Address

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 1-11-45 (month) (day) (year)
(c) Cemetery or crematory Mt Hatrow
Location Newfork City

18 (a) Funeral director Jack Lewis Inc
(b) Address 419 E Balto St

19 (a) JAN 11 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1945, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractures Skull

Due to

Other Conditions Fractured leg bones Lacerations, Contusions & bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 3/7

(a) Date of injury January 6 1945
(b) Where did injury occur? Kiesler & Hanford
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian struck by auto

23. Signature Howard J. Maddox M.D.
Medical Examiner.
Date signed 1-11-45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4 Copies
G24579

BALTIMORE CITY HEALTH DEPARTMENT ✓ G24579
CERTIFICATE OF DEATH 93D Registered No.

1. PLACE OF DEATH: D.O.A
(a) Baltimore City, Maryland
(b) Street address 107 N. Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George John Hafer

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-9801

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Eleanor F Tracy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27, 1895

8. AGE: Years 49 | Months - | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business General Baking Co.

FATHER
12. Name Henry Hafer
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Anna Lohn
15. Birthplace Balto. Md.

16 (a) Informant Mrs Eleanor Hafer
(b) Address 107 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave.
(c) JAN 11 1945 Huntington Williams Asst. (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/9 1945; at 3:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Hypertensive C.V. disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Charles J. Fisher M.D. Medical Examiner.
Date signed 1/9/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G24550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24550 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 Markland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Markland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma J. Myerly

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-05-9501

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife George David

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) July 16-1868

8. AGE: Years 76 | Months 5 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Hezekiah Bittle

13. Birthplace Md.

MOTHER 14. Maiden Name Sarah Worley

15. Birthplace Penna.

16 (a) Informant George D. Myerly

(b) Address 403 Markland Ave

17 (a) Burial (b) Date thereof 1 12 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Trinity Lutheran

Location Taneytown Md.

18 (a) Funeral director Mart & E. Dupuis

(b) Address 7119 Belair Rd.

19 (a) (b)
(Date rec'd by registrar) Washington Witness Registrar

JAN 11 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9 1945, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945 to Jan 9 1945 and that I last saw h alive on Jan 9 1945

Immediate cause of death Arteriosclerotic cardio vascular disease

Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] F. Bragg M.D.

Address 5217 York Rd Date signed 1/9/45

C24581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

C24581 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1416 McHENRY ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 McHENRY ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rhoda H. ZENTZ

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex FEMALE | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife IRA C. ZENTZ

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) APRIL 23-1881

8. AGE: Years 63 | Months 8 | Days 17 | If less than one day hr. min. 16

9. Birthplace Md (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name LEMUEL WILHIDE

13. Birthplace ?

MOTHER 14. Maiden Name CELESTE ANN ESTERLINE

15. Birthplace ?

16 (a) Informant IRA F. ZENTZ

(b) Address 1709 WICKS AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 17-1945 (month) (day) (year)

(c) Cemetery or crematory MEADOWRIDGE

Location

18 (a) Funeral director Roth & B.M. Walter

(b) Address Roth & Steeks Sts

19 (a) Filed JAN 11 1945 (b) Recorded by [illegible] Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 9th 1945, at 5.35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1945 to Jan. 9 1945, and that I last saw her alive on Jan. 9 1945.

Immediate cause of death	Duration
arterio sclerotic nephritis	?
Due to Generalized arteriosclerosis	?
Due to	
Other Conditions Hypertension	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas B. Schreiber M. D.

Address 54 S Fulton Ave Date signed 1-11-45

G24383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1572

X G24384

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Cross Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl James

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/30/44

8. AGE: Years	Months	Days	If less than one day
40 days	1	9	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph James.
13. Birthplace

MOTHER 14. Maiden Name Vivian ?
15. Birthplace

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-11-1945 (month) (day) (year)
(c) Cemetery or crematory Pleasant Crest
Location Towson Md. Balto Co.

18 (a) Funeral director Bryon Thomas W. Knight
(b) Address 121 Aisquith St

19 (a) (Date rec'd by Local Reg.) (b) Registrar

JAN 11 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1945 at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 20 1944 to Jan 9 1945. and that I last saw h e alive on Jan 9 1945.

Immediate cause of death	Duration
Heart failure	
Due to Congenital abnormality of the heart.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address Victor A. Mayer Date signed Jan 11 45

G24583 G24583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1102 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Creighton (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Deane

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1-44

8. AGE: Years 1 | Months - | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Lawrence Edwards

13. Birthplace N.C.

MOTHER 14. Maiden Name Margaret Crawford

15. Birthplace N.C.

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Selma Cemetery

Location Selma N.C.

18 (a) Funeral director J. O. Mitchell & Son

(b) Address 1900 Eutaw Place

19 JAN 11 1945 (b) (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH. Jan 10 1945 at 7 3/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1945 to Jan 10 1945 and that I last saw her alive on Jan 10 1945

Immediate cause of death: Staphylococcal and pneumococcal empyema

Due to: Bronchiectasis and lung abscess — Duration: 7 days+

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ruth Whitehouse M. D.

Address Johns Hopkins Hospital Date signed 1/11/45

G24584

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V13B

G24584 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1837 E. Eager St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1837 E. Eager St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Lathon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lillian Lathon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23 1881

8. AGE: Years 63 | Months 3 | Days 13 | If less than one day hr. min.

9. Birthplace Richmond Co. Va (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Carrie Henderson

15. Birthplace Va.

16 (a) Informant Elenora Carney

(b) Address 1837 E. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Elroy D. Wilson

18 (a) Funeral director

(b) Address 2000 Biddle St

19 (a) (Date received by registrar) JAN 11 1945 (b) Huntington Woodstock, Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1945, at 12:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1944, to Jan 6 1945, and that I last saw h— alive on Jan 6 1945.

Immediate cause of death	Duration
Probable Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Lafferty M. D.

Address 532 N. Bond St Date signed 1/11/45

X

G24585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43D

G24585 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave. + Madison St.
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Hanover St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Edward Nickels

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-7318

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30, 1900

8. AGE: Years	Months	Days	If less than one day
44	2	9	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Southern Hotel

FATHER 12. Name Theodore E. Nickels

FATHER 13. Birthplace Balto Md

MOTHER 14. Maiden Name Margaret Usinger

MOTHER 15. Birthplace Balto. Md

16 (a) Informant Melissa B. Nickels

(b) Address 1605 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 12, 1945 (month) (day) (year)

(c) Cemetery or crematory Balto Cemetery

Location Baltimore Md

18 (a) Funeral director A. Howard Evans

(b) Address 1400 St Paul St

19 JAN 11 1945 (b) (Date rec'd by registrar) Huntington Williamsport Md

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/9 1945, at 9:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1945 to 1/9 1945, and that I last saw h[illegible] alive on 1/9 1945

Immediate cause of death Broncho-Pneumonia — Duration 4 days

Due to

Due to

Other Conditions Uremia 3 months
Hypertensive C. V. Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l. Hosp. Date signed 1/9/45

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G24586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. G21586

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 N. Register St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Helena Henry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Charles Albert Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1906

8. AGE: Years	Months	Days	If less than one day
38	9	8	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name John Rudolph
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Ella McLear
15. Birthplace Baltimore Md.

16 (a) Informant Husband
(b) Address 1702 N. Register St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

JAN 11 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

V8 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1945, at 2:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1945 to Jan 9 1945, and that I last saw her alive on Jan 9 1945

Immediate cause of death: Myocardial Failure — Duration

Due to Rheumatic Heart Disease

Due to Auricular Fibrillation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: R.F.H.D. Aortico mitral Stenosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Robert Braun, M.D.
Address Sinai Hospital Date signed 1/9/45

G24587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1945

G24587

Registered No.

Please write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write your certificates promptly and sign your full names.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3400 Eastern Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6010 Eastern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hopf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife RUBY A. SEIFERT

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 5 1884

8. AGE: Years	Months	Days	If less than one day
60	11	5	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation HOUSEHOLD FURNITURE

11. Industry or business SELF

FATHER
12. Name WILLIAM HOPF
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name BARBARA DOEHM
15. Birthplace BALTIMORE

16 (a) Informant WIFE
(b) Address 6010 EASTERN AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/13/45 (month) (day) (year)
(c) Cemetery or crematory OAKLAWN
Location EASTERN AVE

18 (a) Funeral director CLARENCE E. HOFFMAN
(b) Address 1639 BROADWAY

19 JAN 11 1945 (b) Huntington Williams M.D. Registrar
(Certificate rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1945, at 9 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert C. Graham M.D.
Medical Examiner.
Date signed Jan 10 1945

G24588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24588 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4709 Frankford Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William J. Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Jennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11 1881

8. AGE: Years	Months	Days	If less than one day
63 64	7	29	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name David J. Robinson
13. Birthplace Balto Md

MOTHER
14. Maiden Name Annie Fortmann
15. Birthplace Germany

16 (a) Informant Mrs Annie M. Nunnally
(b) Address 4709 Frankford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd

19 (a) (Date signed by registrar) (b) Huntington Registrar

JAN 11 1945

VS 15)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1945, at 3:55 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gangrene of Intestine

Due to Strangulation of small bowel

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gutman M.D. Medical Examiner.
Date signed Jan 11 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

173

G24589 Registered No.

JO #91199

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not guess at correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 N. Chapel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Bush

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Theresa Bausch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1867

8. AGE: Years	Months	Days	If less than one day
77	9	8	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Christopher (d)
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine (d)
15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 12/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Lord
(b) Address 2024 Orleans St.

19 (a) JAN 11 1945 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 1945 at 4:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 19, 1944 to Jan. 9, 1945, and that I last saw him alive on Jan. 8, 1945.

Immediate cause of death	Duration
Pneumonia	5 days
Peritonitis due to	3 wks.
Due to Perforation Rectum Diverticulitis	
Due to	
Other Conditions Cardiac decompensation ?	

(Include pregnancy within 3 months of death)

Date of operation 12-19-44

Major findings of operation: Peritonitis perforation rectum

of autopsy: Pneumonia with effusion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hauck E. Batton M. D.
Address Balt. City Hosp. Date signed 1/10/45

VS 150

G24590 Zablocki G24590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~617 S. Streeper~~
(c) Hospital or institution: Saint Hbs.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 619 S. Streeper St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Zablocki
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	M.

6 (b) Name of husband or wife John (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8-1904

8. AGE: Years	Months	Days	If less than one day
40	3	1	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. Bialozynski
13. Birthplace Poland.

MOTHER
14. Maiden Name Julia Zameski
15. Birthplace Balto. Md.

16 (a) Informant John Zablocki
(b) Address 619 S. Streeper St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto.

18 (a) Funeral director Wm. S. Fiaktowski
(b) Address 2007 Eastern Ave

19 (a) JAN 11 1945 Huntington Wilkinson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1945, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945, to Jan 9 1945, and that I last saw h.e.r alive on Jan 9 1945.

Immediate cause of death.	Duration
Cardiac Respiratory Failure	
Due to Lupus Erythematosa Disseminata	
Due to	
Other Conditions Bronchopneumonia (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Brown M.D.
Address Sinai Hospital Date signed 1/9/45

153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24591 X 55E

Registered No. G24591

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24591

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): Since 12/14/44
(e) Length of stay in Baltimore (yrs., mos., or days): Since 12/14/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Ky. (b) County
(c) City or town Lexington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 862 Charles Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EUGENE BLAKE

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/8/1928

8. AGE: Years	Months	Days	If less than one day
16	1	1	hr. min.

9. Birthplace Lexington, Ky.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -

FATHER
12. Name Arthur Blake
13. Birthplace Louisville, Ky.

MOTHER
14. Maiden Name Emma Watson
15. Birthplace Lexington, Ky.

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address -Baltimore, Md.

17 (a) Burial (b) Date thereof Jan 12-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Lexington, Ky

18 (a) Funeral director Sam'l M. Chase & Son
(b) Address 638 N. Gilmor St

19 (a) Huntington Williams, M.D.
(Date rec'd by registrar)

JAN 11 1945

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Jan. 9, 1945 at 10:45M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec.14, 1944 to Jan.9, 1945 and that I last saw him alive on Jan. 9, 1945

Immediate cause of death Bronchial pneumonia, right lower lobe

Due to Tumor of the pineal glands

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

Duration
Terminal
First noted 9/1/44

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Baltimore, Md. Date signed 1/10/45

VS 150

NCA-57533

24592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

G24592

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene St.

(c) Hospital or institution:

Univ. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Carroll

(c) City or town Westminster

(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy McDaniel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1-45

8. AGE: Years | Months | Days: 10 | If less than one day: hr. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Hubert McDaniel

13. Birthplace Carroll Co Md

MOTHER

14. Maiden Name Anna Kolff

15. Birthplace Virginia

16 (a) Informant Hubert McDaniel

(b) Address Westminster, Md

17 (a) Jan 12-45 (Burial, cremation, or removal) (b) Date thereof 1-12-45 (month) (day) (year)

(c) Cemetery or crematory Baker Dan

Location Glen Johnsville, Md

18 (a) Funeral director Raymond E. Haugh

(b) Address Union Bridge, Md.

JAN 11 1945 (Date rec'd by registrar) Huntington Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-10 1945, at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 1945 to 1-10 1945, and that I last saw him alive on 1-10 1945

Immediate cause of death: Prematurity - cerebral hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature D. M. Simmons M. D.

Address Univ. Hosp. Date signed 1-11-45

G21593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G24593 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2900 ODONNELL ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 ODONNELL ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME SARAH F. REAGAN

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: JAMES A. REAGAN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): OCT. 21 1883

8. AGE: Years 61 | Months 2 | Days 18 | If less than one day hr. min.

9. Birthplace: BALTIMORE MD. (Town, county, and state)

10. Usual Occupation: TAVERN KEEPER

11. Industry or business: FOR SELF

FATHER
12. Name: SAMUEL HORNEY
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: GERMANY

16 (a) Informant: MARION REAGAN (DAUGHTER)
(b) Address: 2900 ODONNELL ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 12/45 (month) (day) (year)
(c) Cemetery or crematory: OAKLAWN
Location: EASTERN AVE EXT.

18 (a) Funeral director: Lilly & Zeiler Sons.
(b) Address: 403 S. WOLFE ST.

JAN 1 1945 (Date received by Registrar) (b) Williams M.D. Registrar

Funeral for

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 8 1945 at 10/30 PM.

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 15 1944, to Jan. 8 1945, and that I last saw her alive on Jan 8 1945

Immediate cause of death: Mitral Insufficiency, Chronic Myocarditis — Duration: ?

Due to: Terminal Pneumonia — Duration: 3 days

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Joseph Lansbury

Address 444 N. Ellwood Ave Date signed 1/9/45 M. D.

G24594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G24594 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ..... University Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville Rural (If outside city or town limits, write RURAL and give town)
(d) Street No. Warren Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mrs. Mary Kearney

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Edward Kearney
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Apr. 25, 1905

8. AGE: Years 39 | Months 8 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Co. Maryland (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name William Curtis
13. Birthplace [illegible] Maryland

MOTHER
14. Maiden Name Alberta William
15. Birthplace Maryland

16 (a) Informant Edw. W. Kearney
(b) Address Cockeysville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13-45 (month) (day) (year)
(c) Cemetery or crematory Poplar Church
Location Cockeysville Md

18 (a) Funeral director Landon M. Bowles
(b) Address Sparks, Md

JAN 11 1945
(a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1945 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1- 1945, to 1-10 1945, and that I last saw her alive on 1-10 1945.

Immediate cause of death Acute heart failure — Duration .....

Due to Rheumatic Heart disease & Mitral Stenosis

Due to Auricular fibrillation

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature D. W. Minter M. D.
Address Univ. Hosp. Date signed 1-10-45

VS 150

G21595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G21595 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 121 S. Calverton Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 82 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 121 S. Calverton Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Bieber

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Lavina Bieber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 28, 1860

8. AGE: Years 84 | Months 0 | Days 13 | If less than one day hr. min.

9. Birthplace Molton, Mass.
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Christian Bieber
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant William E. Bieber
(b) Address 121 S. Calverton Road

17 (a) Burial (b) Date thereof 1-12-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md.

18. (a) Funeral director Geo. H. Schwab
(b) Address 2101 Fredrick Avenue

JAN 12 1945
(Date received by local registrar) Huntington Willis, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10, 1945, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27, 1944, to Jan. 10, 1945, and that I last saw him alive on Jan 5, 1945

Immediate cause of death: Coronary thrombosis
Duration: 2 Mos.

Due to Arteriosclerotic Heart Disease
Duration: years.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edgar S. Mueller M. D.
Address 2623 Washington Blvd Date signed 1/11/45

G24596 Colbittum G24596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 160a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Lanvale
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1232 W Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Judith Chittum

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1945

8. AGE: Years | Months | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name John H. Chittum
13. Birthplace Rockbridge Co, Va.

MOTHER 14. Maiden Name Georgia B. Chittum
15. Birthplace Rockbridge Co Va

16 (a) Informant John H. Chittum
(b) Address 1232 W Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 12 1945 (month) (day) (year)
(c) Cemetery or crematory
Location Marbrook, Va

18 (a) Funeral director Frederick A Cole
(b) Address 1200 W Lombard St

19 (a) Date rec'd by registrar JAN 11 1945 (b) Washington Williams Myth

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1945, at 11 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to Jan 10 1945, and that I last saw her alive on Jan 10 1945.

Immediate cause of death (a) Prematurity — Duration
(a) Cerebral Hemorrhage
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nicholas Baldwin M. D.
Address West Baltimore General Hosp. Date signed 1/10/45

X

G24597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24597 X 467

Registered No. G24597

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 12/8/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 12/8/44

2. USUAL RESIDENCE OF DECEASED:
(a) State N.J. (b) County
(c) City or town Bivalve
(If outside city or town limits, write RURAL and give town)
(d) Street No. -
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY EDGAR RHOADES

3 (b) If veteran, name war: -

3 (c) Social Security Account No. 176-18-9979

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1879

8. AGE: Years 65 | Months 2 4 5 | Days 6 | If less than one day hr. min.

9. Birthplace Hummelstown, Pa.
(Town, county, and state)

10. Usual Occupation Deckhand

11. Industry or business Merchant Marine

FATHER
12. Name Ames Rhoades
13. Birthplace ? Pa.

MOTHER
14. Maiden Name Lydia Horner
15. Birthplace Pa.

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-11-45 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Roland Park
18 (a) Funeral director A. Lee Adler
(b) Address 644 York Rd.

JAN 12 1945 (Date rec'd by registrar)

(b) Lutherville, Md.

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Jan. 8, 1945, at 9:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 8, 1945 to Jan. 8, 1945, and that I last saw him alive on Jan. 8, 1945.

Immediate cause of death Bronchial pneumonia and gangrene of lower lobe, right lung — Duration: Few days

Due to Carcinoma of ano-rectal region. — Duration: Unk.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12/14/44-Colostomy

Major findings of operation: Epidermoid carcinoma of the ano rectal region with inguinal metastasis

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred Pekarsky M.D.
Address Baltimore, Md. Date signed 1/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

MS-57404

X

G24598
AD-57198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

184a

G24598
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos-28days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

8-7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2010 E. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna Alcorn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28-1863

8. AGE: Years	Months	Days	If less than one day
81	2	0	hr. min.

9. Birthplace Del.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jessie M. Claie (D)
13. Birthplace Germany

MOTHER
14. Maiden Name Sarah Grubb (D)
15. Birthplace Del.

16 (a) Informant Baltimore/ City Hospitals (Records
(b) Address 4940 Eastern Ave. 1-10-45

17 (a) Burial (b) Date thereof 1-10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Nash Blvd.

18 (a) Funeral director Wendel & Humphreys.
(b) Address 1-11 N. Broadway, Y

19 (a) 1 (b)
(Date rec'd by registrar)

Hunting for Wilson Boyd

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28- 1944, at 1 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 19 44, to Dec. 28- 19 44 and that I last saw her alive on Dec. 28- 19 44.

Immediate cause of death Bronchopneumonia — Duration 3 Days

Due to

Due to

Other Conditions Fractured pelvis — 1 mo.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/12
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 11-26-44 at ? M
(c) Where did injury occur? Balt., Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? B.C.H. Infirmary While at work? No.
(Specify type of place)
(e) Means of injury Fell down Slipped + fell in hospital on stairway

23. Signature Houck L. Balton M. D.
Address Balt. City Hosp. Date signed 1/4/45

For R. J. Lubowski, by Howard J. Masella, M.D.

VS 150

G24599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G24599 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3101 W. Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2114 W. Fairmount Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry B. Beckley

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Emma C Beckley

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 6, 1868

8. AGE: Years 76 | Months 7 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (town, county and state)

10. Usual Occupation Retired Paper Carrier

11. Industry or business

FATHER
12. Name John Beckley
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Sophie Nagel
15. Birthplace Baltimore Md

16 (a) Informant Mrs Grace Middleton
(b) Address 103 Birdwood Ave - Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director Geo. W. Sehrval
(b) Address 2101 Frederick Avenue

19 JAN 12 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1945, at 6:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 4 1943, to Jan 11 1945, and that I last saw h[illegible] alive on Jan 5 1945.

Immediate cause of death: Chronic myocarditis — Duration

Due to

Due to

Other Conditions senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. N. Guttermon M. D.

Address 2324 Reisterstown Rd Date signed 7/11/45

X

Every item of information should be carefully supplied. Where exact age is not known, WRITE GRAND, WITH UNFADING INK. Every item of information should be carefully supplied. Where exact age is not known, WRITE GRAND, WITH UNFADING INK. Every item of information should be carefully supplied. Where exact age is not known, WRITE GRAND, WITH UNFADING INK. Every item of information should be carefully supplied. Where exact age is not known, WRITE GRAND, WITH UNFADING INK. Every item of information should be carefully supplied. Where exact age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully s... correct age is especially important. Physicians: please write the c... the causes of death clearly and legibly.

G21660

BALTIMORE CITY HEALTH DEPARTMENT

TN. 73881

CERTIFICATE OF DEATH 937

G24600 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 3 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph McKenna

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 10th, 1869

8. AGE:	Years	Months	Days	If less than one day
	75	9	28	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name James McKenna
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Higgton
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ; Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Cross
Location L. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 JAN 12 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8th, 1945 19 at 12-05 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/11 1942 to 1/8 1945 and that I last saw him alive on 1/8 1945.

Immediate cause of death Cardiac failure — Duration 24 hrs
Due to arteriosclerotic heart disease — ?
Due to — ?
Other Conditions Generalized arteriosclerosis — ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Kenneth Smith M.D.
Address Balt. City Hosp. Date signed 9/11/45

VS 189

G2460 L

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G2460 L

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2641 Dulaney St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2641 Dulaney St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William T. Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Sophia Bailey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 27th 1863

8. AGE: Years	Months	Days	If less than one day
81	11	14	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name (Unknown) Bailey
13. Birthplace

MOTHER
14. Maiden Name Catherine Becraft
15. Birthplace

16 (a) Informant Grace Clevenger
(b) Address 2641 Dulaney St

17 (a) Burial (b) Date thereof 1/13/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Wards Chapel
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 217 St. Paul St.

19 JAN 12 1945 Date rec'd by registrar Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11th 1945, at 7:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to Jan 10 1945, and that I last saw him alive on Jan 10 1945.

Immediate cause of death	Duration
Coronary Occlusion	one day
Due to	
Due to Hypertension Cardiac Failure	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Clevenger M. D.
Address 2687 Woodbourne Ave Date signed Jan 12 1945

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1a

Registered No. G24603

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1803 E. 28th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 - 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3013 Independence St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Wilhelmina (Minnie) C. Propf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~: William F. Propf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6th 1882

8. AGE: Years 63 | Months 0 | Days 4 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Henry Huebner
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Stetten
15. Birthplace Germany

16 (a) Informant William F. Propf
(b) Address 1803 E. 28th St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1/13/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Emanuel
Location Ff Belair Rd - City

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 JAN 12 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10th 1945 at 7:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15, 1944 to Jan. 10 1945, and that I last saw her alive on Jan. 9, 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Arteriosclerotic Cardiovascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James A. Wolfe M. D.

Address 1331 E. North Ave Date signed 1-11-45

VS 190

G-24603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G-24603

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D.O.A. - Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Steinbock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) ~~Single~~, ~~married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or wife: Laura Steinbock

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 15th, 1863

8. AGE: Years 81 | Months 8 | Days 25 | If less than one day hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Inmate

11. Industry or business: Home for Aged

FATHER
12. Name: George Steinbock
13. Birthplace: Germany

MOTHER
14. Maiden Name: Margaret Smith
15. Birthplace: Germany

16 (a) Informant: Records Aged Womens' & Aged Mens' Home
(b) Address: 1400 W. Lexington St.

17 (a) Burial (Burial, ~~Cremation~~) (b) Date thereof 1/12/45 (month) (day) (year)
(c) Cemetery or ~~Crematory~~: Loudon Park
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) Jan. 12, 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-10- 1945, at 4:37 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1943, to 1/10/ 1945, and that I last saw h~~im~~ alive on 19

	Duration
Immediate cause of death: Pt. dead on arrival at U.M.H. probably from coronary thrombosis-sudden.	
Due to: Body released by Dr. Davis medical investigator after	
Due to: usual procedure.	

~~Other Conditions~~: Probable coronary thrombosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

DO NOT COPY

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Irwin B. Jarrett M. D.

Address 11 E. Chase St., City Date signed 2/28/45

VS 150

C24604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1862

Registered No. C24604

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) d-0-a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2535 Penna. ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Richard F. Anderson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Irene Anderson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25th 1899

8. AGE: Years	Months	Days	If less than one day
45	0	15	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Brick Layer

11. Industry or busines Kurtis-Wilson Inc.

FATHER
12. Name Richard F. Anderson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Kate Mc Carty
15. Birthplace Balto. Md.

16 (a) Informant Irene Anderson
(b) Address 2535 Penna Ave

17 (a) Burial (b) Date thereof 1/13/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) JAN 12 1945
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-10- 19 45, at 5-15 P.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemo thorax, Traumatic

Due to Laceration of lung

Other Conditions Fractured ribs + femur

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-10- at 2-35 P M. 25/3
(b) Where did injury occur Factory Bldg Balto. Md + Port
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Caught in a coal conveyor

23. Signature Thomas J. Mullen M.D.
Medical Examiner.
Date signed 1-11-45

VS 151

2460466813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

G24605 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15- E. Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred Johnson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-19-76

8. AGE: Years 68. Months 4 Days 20 If less than one day hr. min.

9. Birthplace Md. (Town, County, and state)

10. Usual Occupation Junk Dealer

11. Industry or business Some

FATHER 12. Name James Johnson

13. Birthplace ? ? ?

MOTHER 14. Maiden Name Molly Ritter

15. Birthplace ? ? ?

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 12-45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Charles P Towell
(b) Address 2427 Edmondson Ave

19 (a) JAN 12 1945 (Date rec'd by Reg.) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan-9 1945, at 8.31 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-6 1945, to Jan-9 1945, and that I last saw him alive on Jan-9 1945.

Immediate cause of death: peritonitis — Duration: 4 days

Due to: perforated peptic ulcer

Due to:

Other Conditions: Had strangulated hernia, developed operation pneumonia (Include pregnancy within 3 months of death)

Date of operation 1-6-45

Major findings of operation: peritonitis, perforated peptic ulcer & strangulated Rt inguinal hernia

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Burch M. D.
Address J-H-H Date signed 1-10-45

G24606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24606 Registered No.

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important. PRINT IN PENCIL, WITH UNFADING INK. ENTER ONE LETTER OR FIGURE IN EACH SPACE.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 304 W Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days) 18 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 304 West Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Victoria Goodwin

3 (b) If veteran, name war

3 (c) Social Security Account No. 229-18-9411

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Chas T Goodwin

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Sept 6 1879

8. AGE: Years 65 Months 4 Days 5 If less than one day ... hr. ... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business home

FATHER 12. Name James Harley

13. Birthplace Warwick Co Va

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Chas T Goodwin

(b) Address 304 W Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15-45 (Month) (day) (year)

(c) Cemetery or crematory Mt Vernon Church

Location Hanover & Va

18 (a) Funeral director Chas J Powell

(b) Address 2427 Edmondson Ave

JAN 12 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11th 1945, at 4a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9 1945 to 1/9 1945, and that I last saw her alive on 1/7 1945.

Immediate cause of death Coronary occlusion — Duration 1/9/45

Due to Arteriosclerotic cardiovascular disease — ?

Due to — ?

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carl P Rostberg M. D.

Address 326 N Lombard St Date signed 1/11/45

G24607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 20 D

Registered No. G24607

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 123 N. Amity St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 123 N. Amity st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lawrence C. Booze

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Married

6 (b) Name of husband or wife Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1908

8. AGE: Years	Months	Days	If less than one day
36 37	7	6	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Charles Booze
13. Birthplace Md

MOTHER
14. Maiden Name Mary Warner
15. Birthplace Md

16 (a) Informant Bessie Booze
(b) Address 123 N. Amity St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Ehrey O. Wilson
(b) Address 1000 Brandt Ave

19 JAN 10 1945 (b) Huntington Williams, M.D. Registrar
Date rec'd by Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7-1945, at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH
Ruptured Aneurysm of Aorta
Due to Syphilis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Seward E. Miller M.D. Medical Examiner.
Date signed 1-8-45

VS 151

G24608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G24608

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 216 Calvin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emanuel Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27 1826

8. AGE: Years 68 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Maine, Ga.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Emanuel Jackson
13. Birthplace Ga.

MOTHER
14. Maiden Name Eliza ?
15. Birthplace

16 (a) Informant Cora Jackson
(b) Address 216 Calvin St

17 (a) Burial (b) Date thereof 1-12-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1900 Pennsylvania Ave

19 (a) JAN 12 1945 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/9 1945 2:25 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 1/9/45

Conscientious & accurate answers to all questions are necessary & important. Physicians: please write the causes of death clearly and legibly.

PRINT OR WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

DUPLICATE

466899 | 46 B | Registered No. 024609

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 E. Madison St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Neal.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-18-90

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name ? Neal

13. Birthplace ? ?

MOTHER 14. Maiden Name Amanda Thomas

15. Birthplace md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof JAN. 12, 1945 (month) (day) (year)

(c) Cemetery or crematory MT. CALVARY

Location 3508 S. HANOVER ST.

18 (a) Funeral director ELDOY O. WILSON

(b) Address 1000 Brantley Ave.

19 (a) JAN. 10, 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1945, at 7.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1945 to Jan 9 1945, and that I last saw him alive on Jan 9 1945.

	Duration
Immediate cause of death anemia, cachexia	2 weeks
starvation	
Due to Carcinoma of stomach & metastases to other tissues	8 mons
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 12/16/44

Major findings of operation: Carcinoma of stomach & metastases to lymph

of autopsy: nodes

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John McLee M. D.

Address The Johns Hopkins Hospital Date signed 4/8/45

VS 150

G24610 ✓ G24610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 825 N. Parrish st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 825 N. Parrish St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Daniels

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-25-1892

8. AGE: Years 52 | Months 2 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James E. Daniels
13. Birthplace Md.

MOTHER
14. Maiden Name Mary.
15. Birthplace Md.

16 (a) Informant Hazel Daniels
(b) Address 825 N. Parrish St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy A Wilson
(b) Address 1000 Brantley Ave

19 (Date rec'd by registrar) JAN 12 1945 Hunting Town Williamsville, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1945, at 1.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944, to Jan 9 1945, and that I last saw h alive on Jan 9 1945.

	Duration
Immediate cause of death Coronary Occlusion	Jan 5, 45
Due to Arteriosclerosis Degeneration	Nov 1, 44
Due to Myocarditis	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert L. Lafarge M. D.
Address 822 N. Bond St Date signed 1/10/45

VS 150

G24611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 G24611 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Green Sts.
(c) Hospital or institution: University 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 40 S. Fremont Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mathew Waitekunas (WATKINS)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or (divorced)

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 43 1902

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Labour

11. Industry or business Maryland Drydock Co.

FATHER
12. Name Mathew Waitekunas
13. Birthplace Lithuania

MOTHER
14. Maiden Name Anna Raber
15. Birthplace Lithuania

16 (a) Informant Anna Waitekunas
(b) Address 40 S. Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Beltsville Rd.

18 (a) Funeral director Joseph Kavanaugh Son
(b) Address 608 Washington Blvd

JAN 12 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1945, at 8 03 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1945, to Jan. 9 1945, and that I last saw h. alive on Jan 9 1945

Immediate cause of death: Pneumococcic Sepsis
Type #2 pneumococcus.
Due to
Due to
Other Conditions Chronic alcoholism, Bilateral lobar pneumonia
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Wirt Hollyes M.D.
Address University Hospital Date signed 1/9/45

Huntington Williams, M.D.

24612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G24612 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 N. Dallad (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Love Fitts
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race Black
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11 - ? - ? 1892
8. AGE: Years 52 Months 2 Days If less than one day hr. min.
9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business
FATHER 12. Name Tom Fitts
13. Birthplace N.C.
MOTHER 14. Maiden Name Lula Herman
15. Birthplace N.C.
16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 12/45 (month) (day) (year)
(c) Cemetery or crematory
Location Littleton N. Carolina
18 (a) Funeral director Mrs. A. Elliott & Daughter
(b) Address 1297 Caroline St.
JAN 12 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1945 at 7 45 AM
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1944 to Jan 10 1945 and that I last saw h[illegible] alive on Jan 10 1945.

Immediate cause of death	Duration
Disseminated tuberculosis of lungs, pleura and	1 year
Due to pleuroneumn.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Albert A. Hatton
Address Johns Hopkins Hosp. Date signed 1/11/45

VS 150

24613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G24613
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 342 E. University
(c) Hospital or institution:
* *
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 342 E University Pkwy
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME AGNES EVANS LAMSBACH

3 (b) If veteran, name war	3 (c) Social Security Account No.	
No	NONE	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	White	Widow

6 (b) Name of husband or wife Albert C. Lamsbach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 16-1861

8. AGE: Years	Months	Days	If less than one day
83	6	24	3 hr. min.

9. Birthplace Phila. Pa
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name JAMES EDWARD EVANS
13. Birthplace WALES

MOTHER
14. Maiden Name AMANDA MILLER
15. Birthplace Phila. Pa

16 (a) Informant GENEVEIVE E. L. MESEILE
(b) Address 342 E. University Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/45 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Lorraine
Location Windsor Mills Road

18 (a) Funeral director Chas F. Evans & Son
(b) Address 118 W. Mt Royal Ave.

(c) JAN 12 1945 Huntington Williams M.D.
(Date received by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1945 at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1931 to Jan 9 1945; and that I last saw h[illegible] alive on Jan 9 1945

Immediate cause of death Myocardial Arteriosclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: Greatest

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. W. Moody
Address 1403 Parkside Date signed 1/10/45

THESE WHITE PEARL, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186B

G24614 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write plainly. Important. Type or print plainly, supplying all requested information.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 725 Pierce St.
(c) Hospital or institution: So. Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or Town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 725 Pierce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Married

6 (b) Name of husband or wife Janie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-23-1884

8. AGE: Years	Months	Days	If less than one day
60	8	18	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Mutual Chem. Co.

FATHER
12. Name Mary Washington
13. Birthplace S.C.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Janie Washington
(b) Address 725 Pierce St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 1-13-45 (month) (day) (year)
(c) Cemetery or crematory Cheney Cem.
Location Greenville S.C.

18 (a) Funeral director Wm. A. Jackson
(b) Address 916 Paulina Ave

19 (a) JAN 12 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11 1945, at 7:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia, Bronchial

Due to Crushed Chest

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 1-8-45 at 3:2 M.
(b) Where did injury occur? 1348 Block St.
(c) Did injury occur at home, on farm, industrial place, in public place? 1348 Block St. While at work? Yes
(d) Means of injury Caught in a bond belt

23. Signature Edward E. Miller M.D. Medical Examiner.
Date signed 1-11-46

VS 151

24615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168

G24615

Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Put correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 924 Jordan St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 924 Jordan St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

V

3 (a) FULL NAME Warren Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 66 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Virginia (Town, county and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name ?

13. Birthplace Va.

MOTHER 14. Maiden Name ?

15. Birthplace Va.

16 (a) Informant Leon Paul

(b) Address 924 Jordan St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave.

19 (a) JAN 12 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 1945, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1944 to Jan 3 1945 and that I last saw h... alive on Jan 2 1945

Immediate cause of death Lobar Pneumonia — Duration

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. C. Pelletreau M. D.

Address 21 Hamilton Ter. Date signed Jan 4 1945

VS 199

24616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G24616 Registered No.

JO #91467

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Queen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
55 ?	?	?	hr. min.

9. Birthplace Unable to obtain information. (Town, county, and state)

10. Usual Occupation

11. Industry or business asphalt block & tile

FATHER
12. Name Unable to obtain information:
13. Birthplace " " " "

MOTHER
14. Maiden Name " " " "
15. Birthplace " " " "

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue.

17 (a) Burial (b) Date thereof 1-15-45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Peter's
Location

18 (a) Funeral director A. Halstead
(b) Address 9/8 Druid Hill Ave.

19 (a) JAN 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10, 1945 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6, 1945 to Jan. 10, 1945, and that I last saw h. in alive on Jan. 10, 1945.

Immediate cause of death	Duration
cerebrovascular accident	4 days
Due to Cerebral arteriosclerosis	?
Due to	
Other Conditions Hypertension Hypertensive Cardio-vasc. disease	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. Kenneth Swink

Address Balt. City Hosp. Date signed 1/11/45

VS 150

G24617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G24617

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 524 Preston St
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 524 Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Warnetta Richardson

3 (b) If veteran, ...e war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1944

8. AGE: Years	Months	Days	If less than one day
	5		hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Grace Richardson
13. Birthplace S. C.

MOTHER
14. Maiden Name Edna Fulwood
15. Birthplace S. C.

16 (a) Informant Mrs. G. Richardson
(b) Address 524 N Preston St.

17 (a) Burial (b) Date thereof 1-12-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sumpter
Location South Carolina

18 (a) Funeral director C. A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) JAN 12 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-10 1945, at M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bilateral Bronchial Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Seward E. Miller M.D.
Medical Examiner.
Date signed 1-11-45

VS 151

Please write the causes of death clearly and legibly. Physicians: please write legibly.

G24618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G24618

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Provident Hospital 14 - 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1351 Fremont Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Moore
13. Birthplace N. C.

MOTHER
14. Maiden Name ?
15. Birthplace N. C.

16 (a) Informant Naomi Moore
(b) Address 1351 Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) JAN 12 1945 (Date rec'd by registrar) (b) Lexington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23, 1944, at 9:50 A.M.

21. I certify that I took charge of the remains described above, held an ____ thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gun shot wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-23-44 at 8 A.M. (Hour)
(b) Where did injury occur? 1856 Pennsylvania Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Firearm Shot in head at home

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed December 23, 1944

VS 151

G24619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G24619

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important. USE BLACK, WASH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 810 George St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 810 George St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Layton
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1876

8. AGE: Years 68 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace Martinsburg, W. Va.
(Town, county, and state)

10. Usual Occupation Junkman

11. Industry or business

FATHER
12. Name George Layton
13. Birthplace W. Va.

MOTHER
14. Maiden Name ?
15. Birthplace W. Va.

16 (a) Informant Mary Layton
(b) Address 810 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Jr. Halstead
(b) Address 918 Druid Hill Ave.
(c) JAN 12 1945 (Date rec'd by registrar) Wilson Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8, 1945, at 7:15 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 12/18 1944 to 1/8 1945, and that I last saw him alive on 1/8 1945.

Immediate cause of death — Hypotensive Type Heart Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis D. Sinks, M.D.
Address 501 N. Calhoun St. Date signed 1/8/45

VS 150

G24620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

G24620 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & Dolphin Sts
(c) Hospital or institution:
W. B. & H. 3rd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt (If outside city or town limits, write RURAL and give town)
(d) Street No. 265 Herring Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Deeds

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			18 hr. min.

9. Birthplace W. B. & H. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Deeds.
13. Birthplace Manchester Tenn.

MOTHER
14. Maiden Name Pearl Strader
15. Birthplace Buckingham W. Va.

16 (d) Informant Wm Deed
(b) Address 265 Herring Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 15 45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto.

18 (a) Funeral director George A. Kershaw
(b) Address 4000 Old York Rd.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JAN 12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1945, at 9.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9 1945, to 1/10 1945, and that I last saw h[er] alive on 1/10 1945.

Immediate cause of death ~~Bronchitis~~ Cerebral Hemorrhage
Due to Bronchitis
Due to
Other Conditions Bronchitis
(Include pregnancy within 3 months of death)

Duration: 18 hrs

Date of operation
Major findings of operation:
of autopsy: Cerebral pulmonal Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury Dr Dugan

23. Signature Dr Dugan M.D.
Address 1st Balto. Date signed 1/10/45 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Gay 1114 St Paul St

G24621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2460 Brentwood AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 13
(e) Length of stay in Baltimore (yrs., mos., or days) 40 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2460 Brent Wood AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SUSIE FORD.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	Colo	MARRIED.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/10/1867

8. AGE: Years	Months	Days	If less than one day
57 58	9	29	hr. min.

9. Birthplace KEYSVILLE VIRGINIA.
(Town, county and state)

10. Usual Occupation DEMESTIC

11. Industry or business

FATHER
12. Name ROBERT HENDERSON
13. Birthplace V.A.

MOTHER
14. Maiden Name ALICE FOSTER
15. Birthplace VIRGINIA

16 (a) Informant FRANK HENDERSON
(b) Address 2460 BRETWOOD AVE.

17 (a) BURIAL (b) Date thereof 1/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West Port

18 (a) Funeral director Raymer Sanders
(b) Address 1412 E. Preston St.

JAN 12 1945 (Name) for Williams
(Date rec'd by registrar)

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/9 1945; at 4. P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from – 1940 to – 1945
and that I last saw h[illegible] alive on 1/8 1945

Immediate cause of death: Coronary occlusion

Due to: Hypertensive Cardio Vascular disease.

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lucy N Gay M. D.
Address 1114 St. Paul St Date signed 1/9/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24622

B-91365

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

30F

G24622 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6hr-55min
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 Brevard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31-1944

8. AGE: Years	Months	Days	If less than one day
			6 hr. 55 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Arthur Butler
13. Birthplace ?

MOTHER
14. Maiden Name Marie Brown
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 1-8-44 3 PM
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. City Hosp.
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 JAN 12 1945 (b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31-1944 19 44 at 2.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31- 1944 to Dec. 31-1944, and that I last saw her alive on Dec. 31- 1944.

Immediate cause of death	Duration
Pulmonary Hemorrhage	
Congenital Syphilis	
Due to	
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Bberry, Jr. M.D.

Address Balto. city Hosp. Date signed 1/5/45 M D

VS 150

G24623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

Registered No. G24623

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address UMH
(c) Hospital or institution: 13-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. UMH (Number and street or R.F.D. route)
3259 Chestnut Ave.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Charnock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-29-44.

8. AGE: Years | Months | Days | If less than one day 4 hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Mr. Henry Charnock
13. Birthplace

MOTHER
14. Maiden Name Mary Virginia Licata
15. Birthplace Pensacola, Florida

16 (a) Informant Hosp.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director Hospital
(b) Address

19 (a) Date received by registrar JAN 2 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29-44 at 11 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1944 to 12-29 1944 and that I last saw her alive on 12-29 1944.

Immediate cause of death Cardio-respir. fail. Duration

Due to Hydrocephalus, and Spina Bifida & Meningocele.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Morris M.D. M. D.
Address UMH Date signed 12-29-44

VS 150

G24624 — AB-91169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G24624 — Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1436 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Doyle

3 (b) If veteran, name war

3 (d) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17-1944

8. AGE: Years	Months	Days	If less than one day
		18 17	hr. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name John Doyle

13. Birthplace Pa.

14. Maiden Name Hazel Norwood

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)

(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 1-8-44 3PM
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore City Hosp

Location 4940 Eastern Avenue

18 (a) Funeral director

(b) Address

19 (a) (b) Huntington Williams, M.D.
Registrar

JAN 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 1945, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1944; to Jan. 3 1945 and that I last saw her alive on Jan. 3 1945.

Immediate cause of death	Duration
pneumonia	3 days
Due to	
Due to	
Other Conditions prematurity	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hugh Perry, Jr. M.D.
M. D.

Address Balt City Hosp Date signed 1/5/45

G24625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

Registered No. G24625

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Maryland General Hosp 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1914 Lord St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Paul A. Reeves

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1939

8. AGE: Years	Months	Days	If less than one day
5	8	20	....hr. ....min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Paul Reeves
13. Birthplace Md.

MOTHER
14. Maiden Name Virginia A. Turner
15. Birthplace Md.

16 (a) Informant Mother
(b) Address

17 (a) Burial (b) Date thereof Jan 13/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ St. Mary's
Location Hampden

18 (a) Funeral director E. Kenower & Sons
(b) Address 2615-17 Eastern Ave

19 (a) JAN 12 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1945 at 4 15 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Skull

.....

.....

Due to.....

.....

Other Conditions.....

.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Jan 10 1945 at 13/2 4 P M.
(b) Where did injury occur? North East Royal Ave
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Struck by truck while sledding

23. Signature Robert Lee Bratton M.D.
Medical Examiner.
Date signed Jan. 11 1945

VS 151

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

2626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55B

G24626 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3105 Brittenton Place.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3105 Brittenton Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Carroll Gibson.

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-0995

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1905

8. AGE: Years 39 | Months 7 | Days - | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Handyman

11. Industry or business Roland Park Co.

FATHER
12. Name Wm Gibson.
13. Birthplace Pa.

MOTHER
14. Maiden Name Lilly Martin.
15. Birthplace Pa.

16 (a) Informant Sarah Nace.
(b) Address 3105 Brittenton Place.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 12 1945 (month) (day) (year)

(c) Cemetery or crematory St Mary's
Location Hampden.

18 (a) Funeral director J. Kenwell & Donovan.
(b) Address 361-5-17 Chestnut Ave.

19 (a) Date received by registrar JAN 12 1945 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov, 1944 to Jan 9 1945, and that I last saw ... alive on ... 19...

Immediate cause of death: Broncho-Pneumonia — Duration

Due to: Carcinomatosis

Due to: Sarcoma Rt. hip.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward L. Passmore M.D.

Address 4037 Falls Rd. Date signed 1/11/45

X

G21627 BALTIMORE CITY HEALTH DEPARTMENT G21627
CERTIFICATE OF DEATH 46E Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6215 Lincoln Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 20
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6210 Lincoln Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME M. RANDOLPH KAHN.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of husband or wife Mary C.R.Kahn.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 11, 1887.

8. AGE: Years	Months	Days	If less than one day
57 56	3 4	22 0	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Physician.
11. Industry or business

FATHER
12. Name Jacob M. Kahn.
13. Birthplace Russia.

MOTHER
14. Maiden Name Bessie R. Shapiro.
15. Birthplace Russia.

16 (a) Informant Mr. A. J. Kahn,
(b) Address Stafford Hotel.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1. 14. 45. (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore Hebrew.
Location Balto. Md.

18 (a) Funeral director Maria Sonnheim & Son
(b) Address 1902 Eutaw Place.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11th. 1945 at A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1942 to Jan 11 1945, and that I last saw h wife alive on Jan 10 1945

Immediate cause of death	Duration
General Carcinomatosis	
Due to Carcinoma of liver + Sigmoid	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Bernard Cole M. D.
Address Marlborough Apts. Date signed 1/12/45

G24628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24628 Registered No.

Please write plainly and legibly. Use ink or indelible pencil. Do not use abbreviations or leave the answers to any questions blank. If the exact information is not known, give the best estimate possible. Fill in the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: DOA Franklin Square Hospy
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 Edmondson (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Peckham

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1873

8. AGE: Years	Months	Days	If less than one day
71	8	19	hr. min.

9. Birthplace New Haven, Conn. (Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS dec JAN 12 1945

Huntington Hillsdale, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10 1945, at 9.40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McAulay Medical Examiner.
Date signed 1/11/45

G24623 — BALTIMORE CITY HEALTH DEPARTMENT — G24623 Registered No.

CERTIFICATE OF DEATH

108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 734 S. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Charles W. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 4/29/1887

8. AGE: Years 57 | Months 8 | Days 9 | If less than one day: hr. min.

9. Birthplace: Erie, Pa. (Town, county, and state)

10. Usual Occupation: -

11. Industry or business: -

FATHER
12. Name: Humphrey Smith
13. Birthplace: [illegible] Pa.

MOTHER
14. Maiden Name: Nellie C. Thompson
15. Birthplace: Pa.

16 (a) Informant: Harry Burton
(b) Address: 352 W. 8th St., Erie, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/45 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151 JAN 12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8th 1945 at 9 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH: Lobar pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Robert Lee Feather M.D. (Medical Examiner.)
Date signed: Jan 9th 1945

C24630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

C24630 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 808 Somerset St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 808 Somerset St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Shirley Eleanor McCoy (Cleary)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Courtney McCoy.

6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) May 5 1920

8. AGE: Years 24 | Months 8 | Days 5 | If less than one day hr. min.

9. Birthplace Norfolk Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Walton Cleary.
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Linder
15. Birthplace Norfolk Va.

16 (a) Informant Courtney McCoy.
(b) Address 808 Somerset St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 13, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director Robert L. Grudge
(b) Address 604 N. Carrollton Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS JAN 12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1945, at 4.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1-44 1945 and that I last saw her alive on 1-10-1945

Immediate cause of death: Pleurisy 2nd Empyema — Duration 2 mos.
Due to: Bronchio Pneumonia — 3 mos.
Due to: Latent Tuberculosis — 2 wks.
Other Conditions: Tuberculosis — Indefinite
(Include pregnancy within 3 months of death)

Date of operation: none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas. R. Blake M. D.
Address 1327 N. Charles St. Date signed 1-11-45

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

4666 8 G24631 BALTIMORE CITY HEALTH DEPARTMENT X V G24631

CERTIFICATE OF DEATH 338

Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hopewell Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Winston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-17-68

8. AGE: Years	Months	Days	If less than one day
76	11	22	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Hemby Winston
13. Birthplace Va

MOTHER 14. Maiden Name Julia ?
15. Birthplace Va

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Jan. 15-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto Co Md

18 (a) Funeral director Robert E. Williams
(b) Address 1575 McElderry St

19 (a) (b) Huntington Ave.
(Date rec'd by registrar) Baltimore, Md.

JAN 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 9 1944 at 4.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan - 4 1944 to Jan - 9 1944 and that I last saw him alive on Jan - 9 1944

Immediate cause of death	Duration
Malignant tumor of bone	1 month
Due to Multiple myeloma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Malignant bone tumor

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ? at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus M. D.
Address Johns Hopkins Hosp Date signed 1/10/45

G24633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G24632 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. and Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 65 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME ~~GEORGE HOWELL PARR~~ Mr. G. Howell Parr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. Ethel H. Parr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/ 8/1879

8. AGE: Years 65 | Months 3 | Days 01 | If less than one day ____ hr. ____ min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business ~~of~~

FATHER
12. Name Henry a. Parr
13. Birthplace Mayland

MOTHER
14. Maiden Name Harriet A. ~~Parr~~ Howell
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Ethel H. Parr. (wife)
(b) Address Warrington Apts.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1-12-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 10th W. NORTH AVENUE

19 (a) (Date received by Registrar) (b) JAN 12 1945 Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/9/45 19 at 10:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9 1945 to 1/9 1945.
and that I last saw h~~im~~ alive on 1/9 1945.

Immediate cause of death: Cardiorespiratory Failure — Duration
Due to Coronary Thrombosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Adelchi Spaziani M. D.
Address UMH Date signed 1-9-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly. ... town or information should be carefully supplied. The

VS 150

X

G24633 ✓ G24633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. .....

Every item of information should be carefully supplied, and if any item is unknown, that fact should be stated. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1307 Decatur St.

(c) Hospital or institution: 3 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1307 Decatur St. (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No) ✓

If yes, name country .....

3 (a) FULL NAME Catherine Nelson

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Joseph Nelson 6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 27, 1886

8. AGE: Years	Months	Days	If less than one day
58	7	12	..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business .....

FATHER 12. Name James Herbert

13. Birthplace Ireland

MOTHER 14. Maiden Name Bridgt Barrett

15. Birthplace Ireland

16 (a) Informant Mercedes Irwin

(b) Address 1307 Deatur St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 12 45 (month) (day) (year)

(c) Cemetery or crematory Mem. Cathedral Cem. Location Old Frederick Rd.

18 (a) Funeral director Fred. J. Krause & Son

(b) Address 216 N. Charles St.

19 (a) ..... (Date received by registrar) (b) Huntington Williams, M.D.

JAN 12 1945

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MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1945, at — M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1944, to Jan 9 1945, and that I last saw h[illegible] alive on Jan 9 1945.

Immediate cause of death Lobar Pneumonia (a) — Duration 6 days

Due to W. J. Mungia — 8 days

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: Int.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature C. B. Mettle M. D.

Address 1079 Williams St Date signed 1/13/45

X

G24634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

G24634
Registered No.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4238 Nicholas Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4238 Nicholas Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tillie Masek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1897

8. AGE: Years	Months	Days	If less than one day
47 yrs.	-	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Kruml
13. Birthplace Czech.

MOTHER
14. Maiden Name Slechta
15. Birthplace Czech.

16 (a) Informant George Masek (husband)
(b) Address 4238 Nicholas Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/45 (month) (day) (year)
(c) Cemetery or [redacted] Baltimore
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street
Attending for Williams, M.D.

19 (a) (Date received by Registrar) (b) Registrar

JAN 12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1945, to Jan 8 1945, and that I last saw her alive on Jan 8 1945.

Immediate cause of death
Pulmonary Edema
Due to Pleurisy
Due to Tuberculosis-P. } Duration Few days / few days / 10 yrs +
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred E. Anderson M.D.
Address 4 W. Preston St. Date signed 1/10/45

G24635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

G24635 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2839 Ashland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2839 Ashland Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES MARTIN ZELENKA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: married

6 (b) Name of ~~husband~~ or wife Lillian Blazek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/11/1885

8. AGE: Years 59 yrs. | Months 1 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business U.S.Marshal's Office

FATHER
12. Name James Zelenka
13. Birthplace Czech.

MOTHER
14. Maiden Name Sott
15. Birthplace Czech

16 (a) Informant James W. Zelenka (Son)
(b) Address 4245 Sheldon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/45 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) JAN 12 1945 Date rec'd by registrar (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1945 at 1.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1944 to Jan 10 1945 and that I last saw h... alive on ... 19...

Immediate cause of death: Carcinoma of Rectum — Duration: 5 mos

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Pokorny M. D.
Address 2200 E. Madison St. Date signed 1/11/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G24637

[redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

Registered No. G24636

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3113 Lee St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3113 Lee St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Beulah Virginia Long

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife James Long
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1896

8. AGE: Years 48 | Months | Days 22 | If less than one day hr. min.

9. Birthplace Anne Arundel Co.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name David Watts
13. Birthplace Anne Arundel Co.

MOTHER
14. Maiden Name Annie ?
15. Birthplace Anne Arundel Co.

16 (a) Informant John Watts
(b) Address College Ave Annapolis, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 14 45. (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location Arnold, Md.

18 (a) Funeral director J. B. Johnson
(b) Address Annapolis, Md.

19 (a) [illegible] (b) [illegible]
(Local registrar)

JAN 12 1945

JAN 1 1945

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11 1945, at 9:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1945 to Jan. 11 1945 and that I last saw h[illegible] alive on Jan 11 1945.

Immediate cause of death	Duration
(a) Acute myocarditis	1 day
Due to (b) Pulmonary edema	1 day
Due to (c) Cerebral Arteriosclerosis	9 days
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. LeRoy Lacy M. D.
Address 1420 E. Chase Date signed Jan. 11 45

G24637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G24637 Registered No.

Please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 10 N. Bethel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
66	4		hr. min.

9. Birthplace md.
(Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mary Jones.
(b) Address 104 Register St

17 (a) Burial (b) Date thereof 1-13-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 E Baltimore St

19 (a) 1-12 1945 (b) Huntington-Williams Mort.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9th 1946 at 7:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Maldeis M.D.
Medical Examiner.
Date signed 1-10-46

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G24638 ✓ G24638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 509 Laurens Street
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 Laurens Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LONNIE C. SMITH

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife: Henrietta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1875

8. AGE: Years	Months	Days	If less than one day
69 68	II	28	hr. min.

9. Birthplace Raleigh, North Carolina. (Town, county, and state)
10. Usual Occupation Crane Operator
11. Industry or business Balto, Copper Wks.

FATHER
12. Name Unknown
13. Birthplace " "

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Lucille Bell
(b) Address 509 Laurens Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof I-13-45 (month) (day) (year)
(c) Cemetery or crematory MT. Calvary
Location Anne Arundel Co.
18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave.,
19 (a) (b) (Filed by registrar) Registrar

JAN 22 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1945 at 8:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/7 1944 to 1/10 1945 and that I last saw h[illegible] alive on 1/9 1945

Immediate cause of death Hepatic Cirrhosis — Duration ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. E. Howell M. D.
Address 2014 Carrollton Ave Date signed 1/12/45

Huntington Williams MD

X

G24639 ✓ G24639

IO #88270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos. 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S. Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Horner (KNOTEK)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife George (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4, 1876

8. AGE: Years 68 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Czazal
13. Birthplace Poland

MOTHER
14. Maiden Name Anna
15. Birthplace Poland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 1/15/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory H. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Radonski & Son
(b) Address 1808 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 180 JAN 12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11, 1945 at 1:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 29, 19 44 to Jan. 11, 19 45, and that I last saw h er alive on Jan. 10, 1945.

Immediate cause of death: Gangrene of Leg with Cellulitis

Due to: Diabetes Mellitus

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Duration: 5-6 mos. ?

Date of operation 11-29-44 12-10-44

Major findings of operation: Diabetic Gangrene of foot,

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Houck E. Baltow, M.D.

Address Balt. City Hosp., Date signed 1/12/45

X

Item of information should be carefully supplied. Every item, with UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24640 ✓ G24640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Williams + Caton Aves.
(c) Hospital or institution St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-15 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 Spaulding Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lola M. Ford

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-05-7153

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John O. Ford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-10-93

8. AGE: Years	Months	Days	If less than one day
51	4	—	hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation Fitter

11. Industry or business Schluegner + Co.

FATHER
12. Name George F. Peregoy
13. Birthplace Maryland

MOTHER
14. Maiden Name Cynthia Bull
15. Birthplace Maryland

16 (a) Informant George F. Peregoy
(b) Address 3504 Spaulding Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 13-1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3691 Falls Road

19 (a) (b)
Registrar

JAN 12 1945

VS 150

Huntington for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/6 1945 to 1/10 1945, and that I last saw h[illegible] alive on 1/10 1945.

Immediate cause of death Heart failure — Duration

Due to Chronic Myocardial Disease

Due to Portal Cirrhosis of the Liver.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edgar E. Carr Jr. M.D.
Address St. Agnes Hosp. Date signed 1/10/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24641 ✓ G24641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 942

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 137 N. LUZERNE
(c) Hospital or institution:

b. ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 137 N. Luzerne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ✓OSEPh OPPEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Mall

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph
13. Birthplace Russia

MOTHER 14. Maiden Name Bailin
15. Birthplace Russia

16 (a) Informant WIFE
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Park Rd & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E Baltimore St

19 (a) [illegible] (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11-45 19 . at ✓ P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-10 1942, to 1-11- 1945, and that I last saw him alive on 1-11- 1945

Immediate cause of death Coronary Thrombosis — Duration 1 hour

Due to Arterio sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack Cohen M. D.
Address 1804 Eutaw Place Date signed 1/12/45

X

correct age is especially important. Physicians: please write the ca... The ... information should be carefully supp... the causes of death clearly and legibly.

G24642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9.7

Registered No. G24642

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address COLD SPRING LANE
(c) Hospital or institution:
LEVINDALE
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 N. Gilmington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abaham Isaac Kvedstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Mar. Married

6 (b) Name of husband or wife Rose Kvedstein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day hr.	min.
72				

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Morris Kvedstein
13. Birthplace Russia

MOTHER
14. Maiden Name Celia
15. Birthplace Russia

16 (a) Informant Rose Kvedstein
(b) Address 14N. Gilmington Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-45 (month) (day) (year)
(c) Cemetery or crematory Pikesville Cem Co
Location Baltimore Co
18 (a) Funeral director Jacob Levin Inc
(b) Address 1439 E. Balto St
19 (a) JAN 12 1945 (Date rec'd by local registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-12 1945; at 7:45 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 6-8 1937 to 1-12 1945 and that I last saw h[illegible] alive on 1-12 1945.

Immediate cause of death	Duration
Arteriosclerosis	
Hypertension	
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Edmund Levin
Address Levindale Date signed 1/12/45

VS 150

X

Persons writing certificate, with CARBON PAPER. Every item or information should be carefully supplied. The causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

G24623 ✓ G24643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Union Memorial Hosp.

(c) Hospital or institution: 33rd and Calvert St.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3902 Canterbury Rd.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] Roberts (Mary Sloan)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Charles B. Roberts

6 (c) If alive, give age [redacted] years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1867

8. AGE: Years 77 | Months 3 | Days 27 | Less than one day ____ hr. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Sloan
13. Birthplace Maryland

MOTHER
14. Maiden Name Abigal Guppman
15. Birthplace Maryland

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13 1945
(month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Henry W. Jenkins Sons
(b) Address Mc Culloh & Orchard Sts

19 (a) (Date received by registrar) (b) Registrar

JAN 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12 1945, at 5 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7 1945, to Jan. 12 1945, and that I last saw her alive on Jan. 12 1945.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Cerebral Accident

Due to Hypertensive Cardio-Vascular Disease

Other Conditions Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Hezekiah Spragins, M.D.

Address UMH Date signed 1-12-45

X

Item of information should be carefully supplied. Every item must be answered, with CAPITALS IN INK. Every item correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH . 50

G24644 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Van Lil St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Anne (Custer) Czyzewski

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business at Home

FATHER
12. Name John Adams
13. Birthplace Baltimore

MOTHER
14. Maiden Name Unk
15. Birthplace Baltimore

16 (a) Informant Frank Czyzewski
(b) Address 701 Van Lil St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 15 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Baltimore

18 (a) Funeral director Fred W. Czyzewski
(b) Address 1949 Eastern Ave.

19 (a) JAN 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1945, at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1945, to Jan 11 1945, and that I last saw h.r alive on Jan 11 1945.

	Duration
Immediate cause of death: Myocardial Failure	
Due to: Bronchopneumonia	
Due to: Carcinoma of Breast	
Other Conditions: Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert Brown M. D.
Address Sinai Hospital Date signed 1/14/45

VS 150

Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24645 | BALTIMORE CITY HEALTH DEPARTMENT | G24645

CERTIFICATE OF DEATH

107

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1601 Cole Street
(c) Hospital or institution:
19

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 Cole Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Ervin Wilson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4. 1933

8. AGE: Years 11 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Portage, Penna.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Merle D. Wilson
13. Birthplace Portage, Penna

MOTHER
14. Maiden Name Ethel May Williams
15. Birthplace Johnstown, Pa

16 (a) Informant Merle D. Wilson
(b) Address 1601 Cole St

17 (a) Removal (b) Date thereof 1-12-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Johnstown Penna.

18 (a) Funeral director Charles D. Schwab.
(b) Address 505 N. Monroe St.

JAN 12 1945
(Date filed) (Registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11, 45 19 , at 3:40 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH,
Bronchial Pneumonia
Internal Hydrocephalus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Edward E. Miller M.D.
(Medical Examiner.)
Date signed January 12, 1945.

G24646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G24646 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2602 Lehman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2602 Lehman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS E. TAYLOR.

3 (b) If veteran, name war: None.
3 (c) Social Security Account No.:

4. Sex: Male. | 5. Color or race: White. | 6 (a) Single, married, widowed, or divorced: Widowed.

6 (b) Name of husband or wife: Catherine Taylor.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30-1880.

8. AGE: Years 64 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Thomas E. Taylor
13. Birthplace Md.

MOTHER
14. Maiden Name Minerva Ware.
15. Birthplace Unknown.

16 (a) Informant Mrs. Gertrude M. Parker.
(b) Address 2602 Lehman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 13-'45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director Charles J. Kehwalt.
(b) Address 505 N. Monroe St.

19 (a) (Signature of registrar) (b) Huntington Williams, M.D. Registrar

JAN 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10th 1945; at 2: A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Jan 10 1945 and that I last saw him alive on Jan 2 1945

Immediate cause of death Coronary Thrombosis
Due to Hypertension Osteitis
Due to
Other Conditions Pulmonary Oedema

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert C. Hatch M. D.
Address 3157 Wilkens Date signed 1-11-45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92E

Registered No. G24647

Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5842 Bellona Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5842 Bellona Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Nellie E. Koethe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~. Married

6 (b) Name of ~~husband~~ or wife L. B. Koethe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6 1891

8. AGE: Years 53 | Months 53 | Days 3 | If less than one day hr. min. 3

9. Birthplace Pikesville Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edwin McGreer
13. Birthplace Pikesville Md

MOTHER
14. Maiden Name Mary Boland
15. Birthplace Ireland

16 (a) Informant L. B. Koethe
(b) Address 5842 Bellona Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13/45 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location Frederick Road

18 (a) Funeral director John A Moran
(b) Address 3000 E Baltimore St

19 (a) JAN 12 1945 (Date received by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9th 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30 1944 to Jan. 9 1945 and that I last saw h[illegible] alive on Jan. 9 1945

	Duration
Immediate cause of death Acute Dilatation Heart	2 days.
Due to Broncho-pneumonia	2 wks.
Due to Endocarditis	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Karl H Berson, M.D.
M. D.
Address 511 York Rd Date Jan 12, 1945

VS 150

G24648 Heatley

BALTIMORE CITY HEALTH DEPARTMENT ✓ G24648

CERTIFICATE OF DEATH 108

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 Harford Road
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick John Heatley ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-23-1899

8. AGE: Years 45 | Months - | Days 19 | If less than one day hr. min.

9. Birthplace New York City
(Town, county, and state)

10. Usual Occupation Sheet metal Worker

11. Industry or business

FATHER
12. Name Sanford ? Heatley
13. Birthplace

MOTHER
14. Maiden Name Margaret ? Comeroy
15. Birthplace

16 (a) Informant Anna M. Heatley
(b) Address 417 E. Lorraine Ave.

17 (a) Burial (b) Date thereof Jan. 15 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Leonard J. Kuck
(b) Address 5304 Harford Rd.

19 (a) 1945 Hunting for Williams
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 19 45 at 4:50 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Purulent meningitis : Lobar pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Le Graham M.D.
Medical Examiner.
Date signed January 12, 1945.

AB-013 G24649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. G24649

Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rural Box 251-Old Battle Grove
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roland J. Gover

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2-1943

8. AGE: Years	Months	Days	If less than one day
1	11	8	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Melvin Gover
13. Birthplace Maryland

MOTHER — 14. Maiden Name Anna Concannon
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Removal (b) Date thereof Jan 14, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fairmount
Location Sunnybrook, Balto. Co., Md.

18 (a) Funeral director Landon M. Brooks
(b) Address Sparks, Md.

JAN 12 1945 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10- 1945, at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1944 to 1-10- 1945 and that I last saw him alive on 1-10- 1945.

Immediate cause of death	Duration
Pneumonia	
Due to 2nd & 3rd degree burns - 60% of body surface	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence DECEMBER 29, 1944 at 3 P. M
(c) Where did injury occur? Box 251 OLD BATTLE GROVE (City or town) BALTO. COUNTY (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME (Specify type of place) While at work? No.
(e) Means of injury SAT IN BUCKET OF HOT WATER.

23. Signature Hugh W. Josephs M.D.
Address Balto. City Hosp. Date signed 1-11-45

For Dr. J. Lubowski, by Howard J. Hendricks, M.D.

G24650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G24650

Every item of information should be carefully supplied, with UNFAILING INK. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1818 Ellamont St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

15 12

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 Ellamont St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NEWTON I. PARR

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bessie W. Parr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1883

8. AGE: Years	Months	Days	If less than one day
61	3	0	hr. min.

9. Birthplace White Hall, Pa.
(Town, county, and state)
10. Usual Occupation Doctor of Medicine
11. Industry or business

FATHER
12. Name Jacob Parr
13. Birthplace Littlestown, Pa.

MOTHER
14. Maiden Name Mary Sponseller
15. Birthplace Littlestown, Pa.

16 (a) Informant Mrs. Bessie W. Parr
(b) Address 1818 Ellamont St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/15/45 (month) (day) (year)
(c) Cemetery or crematory Christ Ch. Cem.
Location Littlestown, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 12 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Jan. 12 1945, at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1, 1944, to Jan. 12 1945, and that I last saw him alive on Jan. 11 1945.

Immediate cause of death: Coronary thrombosis — Sudden death — Duration

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris B. Scherlis M. D.
Address 14 S. Fulton ave Date signed 1-12-45

VS 150

G24651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G24651

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner + Dukeland
(c) Hospital or institution: West Balto. Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 Mosher St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS A DIETER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/16/1883

8. AGE: Years 61 Months 5 Days 24 If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Displays

FATHER 12. Name John W Dieter

13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Bichy

15. Birthplace Md

16 (a) Informant Robt Dieter

(b) Address 1903 Mosher St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem

Location Balto Md

18 (a) Funeral director George A Farley

(b) Address Fulton + Fayette

JAN 12 1945 (Registrar) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10 1945, at 11:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29 1944 to 1/10 1945 and that I last saw him alive on 1/10 1945.

	Duration
Immediate cause of death: Coronary Thrombosis	
Due to: Arteriosclerotic CVD	
Due to: Diabetes Mellitus	
Other Conditions: Gangrene - right foot	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B N Friedman M.D.

Address WB 64 Date signed 1/10/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24652 G24652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

Please write clearly and legibly. Use unfading ink. Do not use pencil. Make certificate for each death. Do not abbreviate. Write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: DOA St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1639 Gilsmuth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Harrison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8 1884

8. AGE: Years	Months	Days	If less than one day
60	3	3	hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Solomon General
13. Birthplace Va.

MOTHER
14. Maiden Name Caroline Mabry
15. Birthplace N.C.

16 (a) Informant Wm. L. General (Son)
(b) Address 2036 W. Lord St. Balto, Md.

17 (a) Burial (b) Date thereof Jan. 15, 1945
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location

18 (a) Funeral director Robert L. Gould
(b) Address 804 N. Carey St
Thurlington Hotel

(Date received by Registrar) Registrar

JN 12 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/11 1945 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh S. McNally M.D.
Medical Examiner.
Date signed 1/12/45

LIDINSKY

G24653

BALTIMORE CITY HEALTH DEPARTMENT JAN 12 1945

Registration No. G24653

CERTIFICATE OF DEATH 85

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 540 N. Linwood A
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5406 Linwood A
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul E. Lidinsky

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1914

8. AGE: Years 30 | Months 11 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Frank Lidinsky
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary Hara
15. Birthplace Balto

16 (a) Informant Frank Lidinsky
(b) Address 5406 N. Linwood A

17 (a) Burial (b) Date thereof 1-13-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md.

18 (a) Funeral director Frank Brady & Son
(b) Address 900 N. Chester St 35

19 (a) JAN 12 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9- 1945, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1938 to Jan 9 1945 and that I last saw him alive on Jan 9 1945.

Immediate cause of death Myocarditis — Duration ____

Due to ____

Due to ____

Other Conditions Epilepsy — Duration 30 yrs

(Include pregnancy within 3 months of death)

Date of operation ____

Major findings of operation: ____

of autopsy: ____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury ____

23. Signature Walter E. Lidinsky M. D.
Address 5939 Harford Rd Date signed 1/11/45

93b

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G24654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G24654

Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 346 W. 29th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 346 W. 29th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Lee Beach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Louisa F. Beach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7th 1873

8. AGE: Years	Months	Days	If less than one day
71	11	4	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Mt. Vernon Mills

FATHER
12. Name (Unknown) Beach
13. Birthplace Va.

MOTHER
14. Maiden Name Mary F. Mills
15. Birthplace Va.

16 (a) Informant Louisa F. Beach
(b) Address 346 W. 29th St.

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 1/15/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

JAN 13 1945 (Date rec'd by registrar)

Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11th 1945, at 12 50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1944 to Jan 11 1945, and that I last saw him alive on Jan 11 1945

Immediate cause of death	Duration
Paralysis	4 days
Due to	
Due to	
Other Conditions Cerebral Hemorrhage	Indef

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. A. Mohrbeck
Address 112 W. 25th St Date signed Jan 11th 45

G24655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30c

Registered No. G24655

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs. ~~or~~ days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) ——

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 E. 32nd St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank A. Wise

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife: Mrs Laura V. Wise

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22 88

8. AGE: Years 56 | Months 0 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Seven Valleys, Pa. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Interstate Commerce

FATHER
12. Name Conrad P. Wise
13. Birthplace Larne Pa.

MOTHER
14. Maiden Name Laura V. Reeder
15. Birthplace Pa

16 (a) Informant Francis A. Wise Jr
(b) Address 1818 E. 32nd St

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1/15/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 JAN 13 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/12/45 19..., at 4 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1944, to 1/12 1945, and that I last saw h~~e~~r alive on 1/12 1945.

Immediate cause of death	Duration
Hypostatic Pneumonia	
Due to C.N.S. Lues	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury?

23. Signature Edward Scanlon M.D.
Address St. Josephs Date signed 1/12/45

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C24656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. C24656

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hosp.
(c) Hospital or institution: Lavalego + Calv. St.
(d) Length of stay in hospital or inst. (yrs., ~~mos.~~ or days) 30
(e) Length of stay in Baltimore (yrs., ~~mos. or days~~) 12

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 E. 20th St. Balto (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Shelkett
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 24th 1894

8. AGE: Years 50 | Months — | Days 17 | If less than one day ___ hr. ___ min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business Retired

FATHER
12. Name Berkely Shelkett
13. Birthplace Va.

MOTHER
14. Maiden Name Virginia Farrow
15. Birthplace Va.

16 (a) Informant Mrs. Va. Farrow
(b) Address 509 E. 20th St.

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 1/15/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Maryland Park
Location Parkville Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 2317 St. Paul St.

19 JAN 13 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11-1945, at 6 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1945 to 1-11-1945 and that I last saw him alive on 1-11-1945

Immediate cause of death Cardio respir. fail. ure

Due to Portal cirrhosis

Due to Uremic poisoning

Other Conditions Ascites.

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

Duration
appx. not 2 yrs.
2 wks.
3 wk.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington L. Cook M. D.
Address Mercy Hosp. Date signed 1-11-45

VS 150

X

From information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G24657
Registered No.

PRESS WHITE PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1549 Argyle Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1549 Argyle Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sarah C. Gordon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colo | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Frank.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1865

8. AGE: Years 79 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace St Mary's Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Jordan
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Nathan Garrison
(b) Address 1549 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-45 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore Md.

18 (a) Funeral director Thos. Law. H. Holland
(b) Address 1631 Druid Hill Ave.

JAN 13 1945
(Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10/45 19 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7/45 19 to 1/10/45 and that I last saw 1/10/45 alive on 19

Immediate cause of death (a) Pneumonia Duration 4 days
Antecedent causes (b) Senility
Due to (c) Arteriosclerosis
Due to
Other Conditions Contributory Nephritis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hilda Allen M. D.
Address 2 W. Mt. Royal Date signed 1/12/45

VS 150

G24658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24658 Registered No. 482

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 E. Lombard st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Brothers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black.	married

6 (b) Name of husband or wife James

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 6-1-93

8. AGE: Years	Months	Days	If less than one day
51	7	9	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Barton
13. Birthplace Va.

MOTHER
14. Maiden Name Elzina Sewells
15. Birthplace Va

16 (a) Informant Reuas
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 12/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location A.A. County Md.

18 (a) Funeral director Mrs. Robert A. Ellicott Dyer
(b) Address 1129 N. Caroline

19 (a) (Date rec'd by registrar) JAN 13 1945 Registrar Huntington Williams, M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 10 1945 at 1.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan - 9 1945 to Jan 10 - 1945 and that I last saw him alive on Jan 10 1945

Immediate cause of death Cerebral hemorrhage — Duration

Due to Hypertensive cardio-vascular disease.

Due to

Other Conditions Sarcoma of uterus with wide spread metastases
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Uterine sarcoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert A. Kattus
Address Johns Hopkins Hosp. Date signed 1/11/45

G24659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G24659

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 E. 33rd St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Brenda Joyce Hardiman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/7/45

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Melvin Carroll Hardiman
13. Birthplace Danville, Va.

MOTHER
14. Maiden Name Marianna Rea
15. Birthplace Bluefield, W. Va.

16 (a) Informant Marianna Hardiman
(b) Address 702 E. 33rd St. Balto, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JAN 12 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 13 1945 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/8 1945, at 9:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7 1945 to 1/8 1945, and that I last saw her alive on 1/8 1945

Immediate cause of death	Duration
Atelectasis	
Anemia	
Due to Prematurity.	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth Aston, M.D. M. D.
Address Hosp. for Women of Md. Date signed 1/9/45

VS 3

2447

X

24669

JL - 90699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G24660 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 26
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2145 Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Nevitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1885

8. AGE: Years 59 60 | Months 8 3 | Days 20 19 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Nebitt

13. Birthplace Md.

MOTHER 14. Maiden Name Alice Holland

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JAN 12 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 JAN 13 1945 (Date rec'd by registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6, 1945 at 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1944 to Jan. 6 1945 and that I last saw him alive on Jan. 6 1945.

Immediate cause of death: CARDIAC FAILURE — Duration: 2 minutes

Due to ARTERIOSCLEROTIC HEART DISEASE — Duration: 2

Due to — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: two post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm Kennedy Smith M. D.

Address Balt City Hosp Date signed 1/9/45

correct age is especially important. Physicians: please write the

VS 150

2446

G24661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24661 Registered No. 467

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1806 N. Gay Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 N. Gay Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace E. Smith

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NONE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edward Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 87

8. AGE: Years 57 | Months 10 11 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Hagerstown Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business AT HOME

FATHER
12. Name George Warner
13. Birthplace Hagerstown Md.

MOTHER
14. Maiden Name Anna Martin,
15. Birthplace Penna

16 (a) Informant Edward Smith, (hus)
(b) Address 1806 N. Gay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/ 15/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly + Jacobs
(b) Address 407 S Wolfe Street

19 (a) JAN 13 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1945 at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1945 to Jan 11 1945, and that I last saw h[illegible] alive on Jan 10 1945.

Immediate cause of death: Coronary Occlusion — Duration: 1 yr
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. S. Gibney, M.D.
Address 622 N. Broadway Date signed 1/12/45

Item of information should be carefully sought for. Every item must be answered, or "unknown" if impossible to obtain. Physicians: please write the causes of death clearly and legibly. Statement of age is especially important.

VS 150

G24662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

G24662 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1809 W. Pratt St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 +
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 W Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Campbell

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Adelaide J.
6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Jan. 14, 1879

8. AGE: Years: 65 | Months: 11 | Days: 29 | If less than one day: hr. min.

9. Birthplace: Hazelton, Penna. (Town, county, and state)

10. Usual Occupation: Storekeeper
11. Industry or business: Confectionery

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Adelaide J. Campbell
(b) Address: 1809 W. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 15 1945 (month) (day) (year)
(c) Cemetery or crematory: St Johns.
Location: Ellicott City Md

18 (a) Funeral director: Robt C + B M. Walters
(b) Address: Pratt + Stricker St.

19 (a) (Date received by registrar) JAN 13 1945 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/12 1945, at 4.45 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Thrombosis

Due to

Other Conditions: Gastric Ulcer

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Hugh B McNalley M.D. Medical Examiner.
Date signed 1/12/45

944a

C24663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 42c

C24663 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 W Conway St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2-2
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 624 W Conway St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Victoria Meredith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Widow

6 (b) Name of husband or wife George Meredith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28 1874

8. AGE: Years	Months	Days	If less than one day
70	11	13	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business

FATHER
12. Name Joseph Watts
13. Birthplace Calvert Co. Md

MOTHER
14. Maiden Name Alberta Hazelhurst
15. Birthplace Kent Island Md

16 (a) Informant Jacob Watts
(b) Address 624 W Madison St

17 (a) Burial (b) Date thereof 1-16-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A Staples
(b) Address 642 N Eutaw St

19 (a) (b) Huntington Williams M.D.
(Date received) Registrar

JAN 13 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1945 at 2 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1944, to Jan 11 1945 and that I last saw her alive on Jan 10 1945.

Immediate cause of death Obstruction
Endocarditis

Due to acute arthritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Greenberg M. D.
Address 624 W Lee Date signed 1/12/45

(OVER)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 D

G24664 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edward and Greene Lds
(c) Hospital or institution: University Hospital 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or ~~town~~ Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 Franklin St. 23 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Mitchell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years: 61 | Months | Days | If less than one day: hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Stevadore

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Violet Moulton
(b) Address 413 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Jamison Stamps
(b) Address 142 Wolfe St

19 JAN 13 1945 (Date received by local registrar) (b) Huntington Withheld, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12 1945 at 2.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1945 to Jan 12 1945 and that I last saw him alive on Jan 12 1945

Immediate cause of death Respiratory failure — Duration 1 wk.

Due to Aortic aneurism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Aortic aneurism

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Millard T. Trabold Jr M.D.
Address University Hospital Date signed 1-12-45

PRINTED WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully secured. Be sure the answer to each question is complete and correct and write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully secured. Be sure the answer to each question is complete and correct are is especially important.

G24665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G24665 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 Russell Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 Russell Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs Wright

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-10-2210

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation laborer

11. Industry or business Kopper Company

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Violet Wright
(b) Address 912 Russell St

17 (a) Burial (b) Date thereof Jan 16-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A Hayes
(b) Address 1442 W Pratt St

19 (a) (Date rec'd by registrar) (b) Registrar

VR-151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11- 1945, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒; accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J Mueller M.D.
Medical Examiner.
Date signed 1-12-45

Huntsville, M.D.

DEC 3 1945

G24666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G24666

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 707 Light St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 707 Light St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah R. Crockett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Francis T. Crockett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
81	80		hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name ? Cross
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mr Crockett
(b) Address 707 Light St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Frederick Rd.

18 (a) Funeral director John F Denny Inc
(b) Address 715 Light St.

19 JAN 13 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/9 1945 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw her alive on 19 .

Immediate cause of death Cardiac Thrombosis
Due to Senile Gangrene
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN - Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Kerr Lyons M.D.
Address 6 E. Randall Date signed 1/12/45

PRINT OR WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G24667

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 dys
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 W. Biddle (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Montiess Grace

3 (b) If veteran, name war: No

3 (c) Social Security Account No. —

4. Sex: F

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/30/37

8. AGE: Years 7 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Evergreen, Ala (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Rance Grace
13. Birthplace Evergreen, Ala.

MOTHER
14. Maiden Name Aurelia Cook
15. Birthplace Evergreen, Ala

16 (a) Informant Mr. Rance Grace
(b) Address 515 W. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date received) JAN 12 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1945 at 11:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1944 to Jan. 10 1945 and that I last saw her alive on Jan 10 1945.

Immediate cause of death 1st., 2nd. and 3rd. degree burns over trunk, arms, buttocks & thighs. — Duration 26 days

Due to

Due to

Other Conditions Anemia; wound infection. (Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Dec. 15, 1944 at 6 P.M.
(c) Where did injury occur? Baltimore, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Burned by flames from oil stove

23. Signature James G. Magee M.D.
Address 1514 Division Date signed 1/12/45

Approved by Howard J. Masters, M.D.

C24668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. C24668

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Paul & 23rd St.
(c) Hospital or institution:
Dr. Beck's Clinic 2-7-12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 316 Woodbourne Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elisabeth Anna [redacted] (BESSIE F.) WALTER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife H. Sigurd Walter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1895

8. AGE: Years	Months	Days	If less than one day
49	0	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Thomas Ford
13. Birthplace Balto.

MOTHER
14. Maiden Name Anna R. Miller
15. Birthplace Balto.

16 (a) Informant Mr. H. Sigurd Walter
(b) Address 316 Woodbourne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 13 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1945 at 10+ M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1945 to Jan 12 1945 and that I last saw h[illegible] alive on Jan 12 1945

Immediate cause of death Subarachnoid hemorrhage
Due to Recurrent hemorrhage
Due to Dec 25 1945 from which she had symptomatically recovered
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 2 hours

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margery S. Beck M.D.
Address 100 E 23rd St Date signed 1-12-45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly

G24669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1111 C

G24669 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 116 S. Collington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 S. Collington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN FREDERICK MILLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Louisa M. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1858

8. AGE: Years	Months	Days	If less than one day
86	2 3	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Salesman (retired)
11. Industry or business -

FATHER
12. Name Hermann Miller
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Katie Zulauf
15. Birthplace -- Md.

16 (a) Informant Rev. Harmon Miller
(b) Address 116 S. Collington Ave.

17 (a) Burial (b) Date thereof 1/15/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 13 1945 (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION P

20. DATE OF DEATH Jan. 11, 1945, at 12:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1945 to Jan 11 1945, and that I last saw n/a alive on Jan 11 1945.

Immediate cause of death	Duration
Pulmonary Edema	1 hr.
Senile changes	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard C. Tickner
Address 432 S. Bellows Spr. Date signed 1/13/45 M. D.

VS 150

G24670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 153

G24670 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County — Co.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5930 Benton ave. (If rural give location)
(e) Citizen of foreign country? Bermuda (Yes or No)
If yes, name country

3 (a) FULL NAME grace davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Harry Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1916

8. AGE: Years 29 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Emmett Arthur
13. Birthplace

MOTHER
14. Maiden Name Margaret Reintzell
15. Birthplace Md.

16 (a) Informant Widow.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 15 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn City
Location

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date received by registrar) JAN 13 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11 1945, at 10 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6-1945 to 1-11 1945. and that I last saw h[illegible] alive on 1-11 1945

Immediate cause of death: Respiratory Obstruction — Duration
Due to: Acute Pemphigus vulgaris
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Dieter
Address Johns Hopkins Hosp. Date signed 1/15/45

VS 150

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G24671 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3320 O'Donnell St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3320 O'Donnell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jane Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1942

8. AGE: Years 2 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John b. Clark
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary A. Webster
15. Birthplace Balto. Md.

16 (a) Informant John b. Clark
(b) Address 3320 O'Donnell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Charles H. Zepp & Son
(b) Address 3605 East Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 15a JAN 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/12 1945 at 4 A M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broncho-pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McSally M.D. Medical Examiner.
Date signed 1/12/45

G24672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G24672

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1043 W. Mulberry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 26

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1043 W. Mulberry St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Marshall Swann

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 217-01-4513

4. Sex: male
5. Color or race: colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Bertha Gray Swann
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Dec 11, 1894

8. AGE: Years	Months	Days	If less than one day
50	1	0	— hr. — min.

9. Birthplace Charles County, Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Steel (Bethlehem)

FATHER
12. Name John Swann
13. Birthplace Charles County, Md.

MOTHER
14. Maiden Name Gertrude Simms
15. Birthplace Charles County, Md

16 (a) Informant Bertha G. Swann
(b) Address 1043 W. Mulberry

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 16, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (Date received by local registrar) JAN 19 1945 (b) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1945, at 7:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1944 to Jan 11 1945, and that I last saw h-m alive on Jan 16 1945

Immediate cause of death: Congestive Heart Failure — Duration: 1.9.45

Due to: Bronchitis — Duration: 12.2.44

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature James M. Pair M. D.
Address 400 N. Carrollton Ave Date signed 1-13-45

Huntington Williams, M.D.
Pair

G24673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G24673

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 404 N Mount
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 N. Mount St (If rural, give location)
(e) Citizen of foreign country? R (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Parker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/25/76

8. AGE: Years	Months	Days	If less than one day
67	1	15	hr. min.

9. Birthplace Frederick Md (Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business —

FATHER
12. Name William Fyan
13. Birthplace Montgomery Co. Md

MOTHER
14. Maiden Name Rebecca Motter
15. Birthplace Frederick Md

16 (a) Informant John W. Fyan
(b) Address 913 Capitol St - Harrisburg Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Nicholas R. Williams
(b) Address [redacted] N Schroeder St

19 (a) JAN 13 1945 (Date received by local registrar) (b) Registered Huntington Rotheram Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10/45 1930 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10/44 to 1/10/45 and that I last saw her alive on 1/9/45 19

Immediate cause of death Cerebral Hem
Due to Arteriosclerosis
Due to Coronary
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
3 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury

23. Signature [illegible] M. D.
Address 97 E Main St Date signed 1/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G24674

G24674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1102 Born Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 Born Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Faunelta Taylor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1894

8. AGE: Years 50 | Months 10 11 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Richards
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Arlene [redacted]
15. Birthplace

16 (a) Informant Arlene Wells
(b) Address 1102 Born Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mr. Winans

18 (a) Funeral director Mc Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by local registrar) JAN 13 1945 (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1945 at 9:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1944 to Jan 9 1945 and that I last saw h er alive on Jan 9 1945

Immediate cause of death: Hypertensive Heart disease — Duration ?

Due to: Hypertension — ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Wallis Shennington M. D.
Address 201 N Carey St Date signed 1/12/45

VS 8

G24675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G24675

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Baltimore
(c) Hospital or institution Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2105 Elsinore Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife: Bessie Mayes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10, 1890

8. AGE: Years	Months	Days	If less than one day
54		26	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Ned. Hill
13. Birthplace Md.

MOTHER
14. Maiden Name Henrietta Taylor
15. Birthplace Md.

16 (a) Informant Mr. Geo. Hill
(b) Address Berlin Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
(d) Location Baltimore Md

18 (a) Funeral director Harry H. Witzke
(b) Address 1101 E Monument Ave

19 JAN 13 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/11/ 1945 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25 1944 to 1/11 1945, and that I last saw h/M alive on 1/4/ 1945.

Immediate cause of death Bilateral Bronchopneumonia — Duration 19 days

Due to Osteomyelitis

Due to Fracture of neck of right femur

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 10/30/44
Major findings of operation: Fracture of neck of right femur
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence October 1944 M
(c) Where did injury occur? 2105 Elsinore Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At home While at work? No (Specify type of place)
(e) Means of injury Fell [illegible] in right bath

23. Signature Frank L. Bradenum M. D.
Address West Baltimore General Hospital Date signed 1/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS

Approved Jan. 13 1945 per Robert Lee Davis M.D. Deputy Health Commissioner M.D.

G21676

G21676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 529 Wildwood Pkwy.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 529 Wildwood Pkwy. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie A. Bothner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow

6 (b) Name of husband or wife late Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day. yr.) April 13, 1866

8. AGE: Years	Months	Days	If less than one day
78	8	23	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Smith
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name ~~Etta~~ Delman
15. Birthplace Md

16 (a) Informant Miss Naomi Bothner
(b) Address 529 Wildwood Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md

18 (a) Funeral director Harry W. Witzke
(b) Address 4101 E. Monument Ave

19 (a) JAN 13 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1945, at 4.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/44 1944 to 1/10 1945, and that I last saw h alive on June 9 1944.

Immediate cause of death Bronchopneumonia Terminal — Duration 2 days

Due to Pyelonephritis — 6 Months

Due to Cardiovascular Disease — 5 years

Other Conditions Chronic Arteriolar Nephritis — 10 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elliot W. Johnson M. D.

Address 3432 Druid Park Drive Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24677 (1)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G24677

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4404 Glenarm Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4404 Glenarm Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick D. Wagner

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Leona
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10 1862

8. AGE: Years 82 | Months 3 | Days - | If less than one day: hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Casper Wagner
13. Birthplace Balto.

MOTHER
14. Maiden Name Wolterum
15. Birthplace Germany

16 (a) Informant Magdalena C. Crosby
(b) Address 4404 Glenarm Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 13 45 (Month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd.

18 (a) Funeral director Martin F. E. Dugan
(b) Address 3110 Belair Rd

19 (a) JAN 12 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1945 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9 1944 to 1-10 1945 and that I last saw him alive on 1-3 1945

Immediate cause of death: Myocardial Degeneration — Duration: 5 yrs +
Due to: Arterio Sclerosis — "
Hypertension — "
Due to:
Other Conditions: Senility

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 6304 Belair Rd Date signed 1/10/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

SIERACKI

G24678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G24678

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 613 S Bond St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 613 S. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Sieracki
3 (b) If veteran, name war
3 (c) Social Security Account No. None

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: James Sieracki
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1895
8. AGE: Years 50 | Months | Days | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name Antoni Nowicki
13. Birthplace Germany.

MOTHER
14. Maiden Name Unk
15. Birthplace Germany.

16 (a) Informant James J. Sieracki
(b) Address 613 S. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 16/45 (month), (day), (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18 (a) Funeral director Frank W. Ozarowski
(b) Address 1930 Eastern Ave

19 (a) Filed JAN 13 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12 1945, at M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944, to Jan 12 1945, and that I last saw her alive on Jan 12, 1945.

Immediate cause of death: Toxemia — Duration
Due to Carcinoma of Stomach
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Mannyanonee M. D.
Address Balto 6. Date signed 1/13/45

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G24679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56E

Registered No. G24679

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Scott Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Edward Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: M | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/11/1919

8. AGE: Years 25 | Months 1 | Days — | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Albert E. Roberts
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Florence Kidwell
15. Birthplace Baltimore Md.

16 (a) Informant Florence Roberts
(b) Address 1004 Scott st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Rd

18 (a) Funeral director Ambrose Sons
(b) Address 714 N Franklintown Rd

19 (Date received by Registrar) JAN 13 1945 (Signature of Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1945 at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to Jan 11 1945, and that I last saw him alive on Jan 10 1945.

Immediate cause of death: Resp failure — Duration

Due to Tumor of Pituitary Gland Frolichs' type

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Tumor

Pituitary Gland

of autopsy: Pituitary Tumor

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Ellis M. D.
Address Univ. Hospital Date signed 1/13/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24680 ✓ 059129

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 159 Registered No. b 24680

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson 4 (If outside city or town limits, write RURAL and give town)
(d) Street No. 203 Courtland Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Baby Boy Barnes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Newborn

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1/11/45

8. AGE: Years	Months	Days	If less than one day
		2	..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Newborn
11. Industry or business

FATHER
12. Name Leroy Lee Barnes
13. Birthplace Chestertown, Md.

MOTHER
14. Maiden Name Elizabeth Mary Strong
15. Birthplace Philadelphia, Pa.

16 (a) Informant Mrs. Elizabeth Strong Barnes
(b) Address 203 Courtland Ave. Towson 4, Md.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 7 1945 (month) (day) (year)
(c) Cemetery or crematory St. Paul's
Location Near CHESTERTOWN, Md.

18 (a) Funeral director J. Willis Wells
(b) Address Chestertown, Md.

19 (a) 1-1945 (Date received by registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/13/ 1945, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1945, to 1/13 1945, and that I last saw him alive on 1/13/1945.

Immediate cause of death	Duration
Respiratory failure	
Due to prematurity	2 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature Dean Pasichal, M. D.
Address Univ. Hospital Date signed 1/13/45

VS 8

G24681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

✓ G24681 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 613 Hollen Rd # 13
(c) Hospital or institution:
Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City ~~or town~~ Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 Hollen Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora M. Miller

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or ~~wife~~ Chas H. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9th 1877

8. AGE: Years	Months	Days	If less than one day
67	7	4	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business At Home

FATHER
12. Name Alford Smith
13. Birthplace Va.

MOTHER
14. Maiden Name Mary E. Taylor
15. Birthplace Balto. Md.

16 (a) Informant Charles H. Miller
(b) Address 613 Hollen Rd.

17 (a) Burial (b) Date thereof 1/15/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) 1217 St. Paul St

19 (a) (b) Registrar
(Date rec'd by registrar)
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-13 1945, at 12:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-7 1945, to 1-13 1945; and that I last saw h~~er~~ alive on 1-12 1945.

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to Arteriosclerosis	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Hosp. Date signed 1-13-45

JAN 14 1945

83b

G24683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1228

G24683 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette + John Street
(c) Hospital or institution:
Women's Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Balt. 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Kimble Rd. 3812
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Claiborne Walter

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Joseph M. Walter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1st 1903

8. AGE: Years	Months	Days	If less than one day
41	3	12	16 hr. 50 min.

9. Birthplace Richmond Virginia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Claybourne G. Chiles
13. Birthplace Va.

MOTHER
14. Maiden Name Julia Blick
15. Birthplace Va.

16 (a) Informant Joseph M. Walter
(b) Address 3812 Kimble Rd

17 (a) Burial (b) Date thereof 1/15/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mayland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) JAN 14 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/12/45 19 ..., at 4:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944, to Jan 12 1945, and that I last saw her alive on Jan 12 1945

Immediate cause of death Circulatory Failure — Duration

Due to Surgical Shock

Due to Ileo-Transverse colostomy for chronic intestinal obstruction & multiple fecal fistulae following Abd. Abcess Origin (?)

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Jan 12 45

Major findings of operation: Massive intestinal adhesions

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Felix Rutledge M. D.
Address Womens Hospital signed 1/12/45

Correct age is supremely important. Physicians: please write the causes of death clearly and legibly.

G24685 ✓ G24685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 Allendale st.
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 Allendale st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alfred H. Tulley

3 (b) If veteran, name war W | 3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Annie Tulley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6th 1865

8. AGE: Years	Months	Days	If less than one day
80	0	5	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Tool Maker

FATHER
12. Name Alfred H. Tulley
13. Birthplace Md.

MOTHER
14. Maiden Name Not Known
15. Birthplace "

16 (a) Informant Mrs Nettie Simering
(b) Address 621 Allendale St.

17 (a) Burial (b) Date thereof 1/15/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location a. a. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) 1945 Jan 13 (b) Wm. Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11th 1945 at 11 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1944 to Jan. 11 1945 and that I last saw h~~im~~er alive on Jan. 10. 1945.

Immediate cause of death Myocardial insufficiency with congestive failure - Arteriosclerotic type — Duration

Due to Heart disease with cardiac hypertrophy generalized arteriosclerosis

Due to

Other Conditions Hemiplegia due to cerebral hemorrhage - 15 years ago.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Michel M. D.
Address 2401 Edmondson ave Date signed Jan 12 1945

VS 150

G24684 G24684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1178a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2322 Orleans Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2322 Orleans Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Sherr

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-01-0023

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Fleck-Sherr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Abraham-
13. Birthplace Russia

MOTHER
14. Maiden Name Esther
15. Birthplace Russia

16 (a) Informant Samuel Sherr
(b) Address 3819 W. Belvedere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-45 (month) (day) (year)
(c) Cemetery or crematory Har Israel Cem.
Location Northern Ave.,

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) 1945 (Entered by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-13- 1945 at 7:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy-Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating gas.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-13- at A.M.
(b) Where did injury occur? 2322 Orleans St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury Unlit small gas heater

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 1-13-45

VS 151

G24685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 108

G24685 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 Chesterman St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 533 Chesterman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Bertram McCanada Dailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	married

6 (b) Name of husband or wife Eleanor C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1882

8. AGE: Years	Months	Days	If less than one day: hr.	min.
62	4	6		

9. Birthplace Cedartown Ga.
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

MOTHER / FATHER

12. Name — Dailey

13. Birthplace Va. Va.

14. Maiden Name — Dailey

15. Birthplace Va. Va.

16 (a) Informant Eleanor C. Dailey

(b) Address 533 Chesterman St

17 (a) Burial (b) Date thereof Jan. 14, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.

Location Balto. Co. Md.

18 (a) Funeral director Mrs. George H. Hubbard

(b) Address 1634 Druid Hill Ave

19 (a) (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

JAN 14 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10 1945, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5-1944 to 1/10 1945, and that I last saw h alive on 1/10 1945

Immediate cause of death Lobar Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ben R Lutts M. D.

Address 2139 Druid Hill Ave Date signed 1/12/45

G24686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G24686
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 Walnut ave 22
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida B Galter

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Carl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8. 1870

8. AGE: Years	Months	Days	If less than one day
74	9	5	hr. min.

9. Birthplace Lancaster Co Pa
(Town, county, and state)
10. Usual Occupation Housemaid
11. Industry or business

FATHER
12. Name Noah Ehrhardt
13. Birthplace Lancaster Co. Pa

MOTHER
14. Maiden Name Unknown
15. Birthplace Pa

16 (a) Informant Paul Rough
(b) Address Dundalk Md

17 (a) Burial, cremation, or removal (b) Date thereof 1/14/45
(month) (day) (year)
(c) Cemetery or crematory McKeesport
Location McKeesport Pa

18 (a) Funeral director Milton Colvin
(b) Address 1219 E Pratt St

JAN 14 1945
(Date registered) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-13 1945, at 8.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12 1945, to 1-13 1945, and that I last saw her alive on 1-13 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Josephs Hosp. Date signed 1-13-45

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

AB-91548 G24687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24687 Registered No. 124a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2225- Essex St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Laskey (Baclawski)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14-1907

8. AGE: Years 37 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Joseph Baclawski
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Zielinski (D)
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 16 /45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore County

18 (a) Funeral director John M. Welby
(b) Address 401 S. Chester Street

19 (a) Filed 1945 (b) Recorded by registrar Washington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12- 1945, at 3.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11- 1945, to 1-12- 1945, and that I last saw him alive on 1-12- 1945

Immediate cause of death. Hepatic nonfunctioning

Due to Jaundice Cirrhosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Negative

Duration
P
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D M Phillips
Address Balto City Hosp Date signed 1-12-45

VS 150

Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G24688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G24688

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Co.
(c) City or town Brooklandsville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Douglas Gordon Carroll

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Amelie Hack
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-14-82

8. AGE: Years	Months	Days	If less than one day
62	5	29	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Stock broker
11. Industry or business

FATHER
12. Name John M. Carroll
13. Birthplace Md.

MOTHER
14. Maiden Name Mary L. Thomas
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 15 1945 (month) (day) (year)
(c) Cemetery or crematory St Thomas
Location Garrison Forest Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address 24 E Fulton St Orchard 4400

19 (a) JAN 15 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1945 at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1945 to Jan 12 1945 and that I last saw him alive on Jan 12 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary Thrombosis	
Due to Arteriosclerotic heart disease	
Other Conditions Hypertension Urinary tract infection	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph D. B. King M.D.
Address Hopkins Hosp. Date signed 1/14/45

VS 150

X

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

24689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G24689

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carolnie St.
(c) Hospital or institution: St. Josephs Hospital 9/3
(d) Length of stay in hospital or inst. (yrs., mos., days) ... days
(e) Length of stay in Baltimore (yrs., mos., or days) ...

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ...
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2526 Mc Culloh St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country ...

3 (a) FULL NAME George P. Bush

3 (b) If veteran, name war ...

3 (c) Social Security Account No. ...

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Mary C. Bush
6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Dec 20 1886

8. AGE: Years	Months	Days	If less than one day
58	0	22	hr. ... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Furrier
11. Industry or business

FATHER
12. Name George Bush
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Bush
15. Birthplace Md

16 (a) Informant Mary C. Bush
(b) Address 2526 Mc Culloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Mrs. Geo. A. Stallard
(b) Address 1631 Druid Hill Ave.

JAN 15 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11 1945 at 9 25 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945 to Jan 11 1945, and that I last saw him alive on Jan 11 1945.

Immediate cause of death	Duration
Cerebra vascular Accident	
Due to Essential Hypertension	
Due to ...	
Other Conditions ...	

(Include pregnancy within 3 months of death)
Date of operation ...
Major findings of operation: ...
of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ... (Specify type of place)
(e) Means of injury ...

23. Signature Edmund Scavare M.D.
Address St. Josephs Hospital Date signed 1/14/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

24690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

G24690 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 115 N. Linwood avenue
(c) Hospital or institution: -----
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 N. Linwood avenue
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME KATHARINE BOOKER TRAVERS

3 (b) If veteran, name war: ---
3 (c) Social Security Account No. ---

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Howard Travers
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 18, 1880
8. AGE: Years 64 | Months 6 | Days 23 | If less than one day: hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name John Adam Booker
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Katharine Meyers
15. Birthplace Balto. Md.

16 (a) Informant Howard Travers
(b) Address 115 N. Linwood avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 15/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director Chas J. Evans & Son
(b) Address 118 N. Mt. Royal Ave

19 JAN 15 1945 (Date received by local Reg.) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan/ 11 1945, at 3:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1943, to Jan 11 1945, and that I last saw h[illegible] alive on Jan 9 1945.

Immediate cause of death: Coronary thrombosis
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: no

Duration: 10 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide? no.
(b) Date of occurrence at M
(c) Where did injury occur? none
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury none
23. Signature E. R. Grady M.D.
Address 5706 Harford Road Date signed 1-11-45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24691 ✓ G24691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

Type or print the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland Sts.
(c) Hospital or institution: West Balto General - D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) *
(e) Length of stay in Baltimore (yrs., mos., or days) *

2. USUAL RESIDENCE OF DECEASED:
(a) St. N 174 (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 Ferndale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl R. Ostrander

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife HELEN C. OSTRANDER
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Oct 14 - 1879

8. AGE: Years	Months	Days	If less than one day
65	2	29	hr. min.

9. Birthplace New York
(Town, county, and state)
10. Usual Occupation SALESMAN
11. Industry or business INSURANCE

FATHER
12. Name Charles G. Ostrander
13. Birthplace New York

MOTHER
14. Maiden Name Julia Brundwell
15. Birthplace New York

16 (a) Informant Helen Ostrander
(b) Address 3002 Ferndale Ave

17 (a) Cremation (b) Date thereof 1 - 15 - 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount - North Aves

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 18 W. Mt. Royal Ave

19 (a) JAN 15 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/13 1945, at 1:25 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Clinton J. Tulbrieht M.D.
Medical Examiner.
Date signed 1/17/45

VS 151

G24692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G24692

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 518 S. Smallwood St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 518 S. Smallwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. High

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of ~~husband or~~ wife: Mabel I. High
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2nd 1882

8. AGE: Years	Months	Days	If less than one day
62	8	21	hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual Occupation: Machinist
11. Industry or business: B. & O. R. R.

FATHER
12. Name: George High
13. Birthplace: Md.

MOTHER
14. Maiden Name: Harriett (Unknown)
15. Birthplace: Md.

16 (a) Informant: Martin A. High
(b) Address: 518 S. Smallwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Meadow Ridge
Location: Dorsey Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St.

19 JAN 15 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12th 1945 at 4 05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 31 1944, to Jan 12 1945, and that I last saw h[im] alive on Jan 12 1945.

Immediate cause of death	Duration
My bronchitis	
Acute lobar Pneumonia	
Pulmonary Infarction	
Due to	
Due to	
Other Conditions Pulmonary Oedema	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Hatch M. D.
Address 2151 Wilkens Ave Date signed 1/14/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item or information should be carefully supplied.

VS 190

2 1693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

✓ G24693 Registered No.

Use ink or typewriter. Fill in all items. If unknown, say so. Do not leave blanks. If death occurred in hospital or institution, give street address or location instead of name. Certificate must be filed with the Registrar of the district in which death occurred within 5 days after death and before burial or removal from the district. Underline the cause on which the coroner's verdict is based. Write cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 844 W. Fayette ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 844 W. Fayette ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Mc Guire

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 15th 1945 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo S. Leach
(b) Address 1201-03 N. Patterson Park Ave

JAN 15 1945 (Date received by Registrar) (Name) Washington Williams M.D.

MEDICAL CERTIFICATION 45

20. DATE OF DEATH Jan 6 1944, at M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerosis
Cardiovascular - renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Jan 6 1944

VS 151

G24694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73D

Registered No. G24694 (over)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST
(c) Hospital or institution: SINAI HOSPT 2916

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town insert name of INCORPORATED PLACE or write RURAL and give town)
(d) Street No. 3321 VIRGINIA BURLEITH AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HYMAN LONDON

3 (b) If veteran, name war ✓
3 (c) Social Security Account No.

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife FLORENCE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~MARCH~~ OCTOBER 15-1885

8. AGE: Years 59 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation TYPE SETTER
11. Industry or business

FATHER
12. Name MEYER
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant DAVID WOOLF
(b) Address 3912 DORCHESTER RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-15-45 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location PHIL RD + HAMILTON AVE

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST.

JAN 15 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14 — 1945, at 3.4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death Cardiac Failure — Duration
Due to Aplastic Anemia
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm S Arnett M. D.
Address Sinai Hosp Date signed 1-15-44

VS 150

Approved: Robert Lee Bratton M.D. Jan 15 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47d

Registered No. G24695

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2922 Pinewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2922 Pinewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Salvatore Cureri

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) ~~Single, married~~, widowed, or divorced.

6 (b) Name of husband or wife Angelina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27-1885

8. AGE: Years 59 | Months 5 | Days 15 17 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Fruit Business

11. Industry or business

FATHER
12. Name Salvatore Cureri
13. Birthplace Italy

MOTHER
14. Maiden Name Rose Liberto
15. Birthplace Italy

16 (a) Informant Carmella Cureri
(b) Address 2922 Pinewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/45 (month) (day) (year)
(c) Cemetery or crematory Mount Holy Redeemer Cem.
Location Belair Road

18 (a) Funeral director Joseph Fanara Inc.
(b) Address P.O. Box Greenmount Ave.

JAN 15 1945
(Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 1945, at 1:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1945 to Jan 13 1945, and that I last saw h[illegible] alive on Jan 13 1945.

Immediate cause of death Metastatic Carcinoma

Due to Primary Ca of Lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 5707 Belair Rd Date signed 1-14-45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G24696

1696

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 27

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 Bennington Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Florence Ruhl

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 31 1872

8. AGE: Years 72 | Months 11 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER } FATHER

12. Name Wm. Ruhl
13. Birthplace Md.
14. Maiden Name Lucinda Young
15. Birthplace Md.

16 (a) Informant Wm. Blayne Myers
(b) Address Upperco, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 18 1945 (month) (day) (year)

(c) Cemetery or crematory Hereford Baptist Ch.
Location Monkton, Md.

18 (a) Funeral director Landon & Mr. Brown
(b) Address Sparks.

19 (c) JAN 15 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15 1945, at 12 25 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1945 to 1/15 1945, and that I last saw her alive on 1/15 1945

Immediate cause of death Cerebro vascular accident — Duration .....

Due to Hypertensive C.V. Lesions — Duration .....

Due to ..... — Duration .....

Other Conditions .....

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: .....
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature J. Carl Myers, M. D.
Address Franklin Sq. Hosp. Date signed 1/15/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G24697

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood + Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 8 day
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: MD (b) County: Frederick
(c) City or town: FREDERICK
(If outside city or town limits, write RURAL and give town)
(d) Street No.: ROUTE 6, ROCKY SPRINGS
(If rural give location)
(e) Citizen of foreign country?: (Yes or No)
If yes, name country:

3 (a) FULL NAME: CHARLES HANSHEW

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Anna E. HANSHEW

6 (c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): MAR. 24, 1873

8. AGE: Years: 71 | Months: 9 | Days: 19 | If less than one day: hr. min.

9. Birthplace: ROCKY SPRINGS MD
(Town, county, and state)

10. Usual Occupation: FARMER

11. Industry or business:

FATHER
12. Name: PHILIP HANSHEW
13. Birthplace: ROCKY SPRINGS MD

MOTHER
14. Maiden Name: ANNIE DELAUTER
15. Birthplace: MD

16 (a) Informant: MRS RENA HANSHEW
(b) Address: ROCKY SPRINGS. MD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 1/16/45 (month) (day) (year)
(c) Cemetery or crematory: ROCKY SPRINGS
Location: FREDERICK MD

18 (a) Funeral director: M. R. ETCHISON
(b) Address: FREDERICK MD

19 (a) JAN 15 1945 (Registered by) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 13 1945, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1945, to Jan 13 1945, and that I last saw him alive on Jan 13 1945.

Immediate cause of death	Duration
Cerebral embolism	
Due to: Auricular fibrillation	
Due to:	
Other Conditions: Uremia	

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Chas. E. Cassel M. D.
Address: Redwood + Greene Sts Date signed: 1/13/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24698 467019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G24698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1334 N. Washington (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Wooden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Geo. Wooden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-9-94

8. AGE: Years 50 | Months 4 | Days 4 | If less than one day hr. min.

9. Birthplace md. (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Henry Nebendein
13. Birthplace md.

MOTHER
14. Maiden Name Catherine
15. Birthplace md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 228 E. Pleasant St. Huntington for Williams, Mgr

19 JAN 15 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13 1945 at 1245 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1945, to Jan. 13 1945, and that I last saw Dec. alive on Jan. 13 1945.

Immediate cause of death Uremia
Cardiac failure
hypertension C-V.
Due to renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Whittlesey M. D.
Address J. H. H. Date signed 1-13

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G24693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G24693

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 38 N. Decker Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 38 N. Decker Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHANNA BROGHAMMER

3 (b) If veteran, name war	3 (c) Social Security Account No.
---	---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Christian C. Broghammer
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) May 6, 1878

8. AGE: Years	Months	Days	If less than one day
66	8	8	..... hr. ..... min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Henry Siemon
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Rausch
15. Birthplace Germany

16 (a) Informant Christian C. Broghammer
(b) Address 38 N. Decker Ave--24

17 (a) Burial (b) Date thereof 1/18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Colgate Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.

19 (a) JAN 15 1945 (b) Huntington Williams, M.D.
(Registered by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 14, 1945 19 6:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1945 to Jan 14 1945 and that I last saw h-lr alive on Jan 13 1945

Immediate cause of death	Duration
Coronary Thrombosis	1/12/45
Due to arterio - sclerosis	2 yrs
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —
23. Signature Louis P. Krumbaar M. D.
Address 722 S. Linwood Date signed 1/15/45

VS 150

24700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G24700

Every item of information should be carefully supplied. Write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 S Stricker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 S. Stricker St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis E. Layman Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife late Ella King

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1878

8. AGE: Years 67 | Months 10 | Days 22 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Robert Layman
13. Birthplace —

MOTHER
14. Maiden Name Laura —
15. Birthplace —

16 (a) Informant Mrs. Francis Layman Jr.
(b) Address 410 S. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director Harry A. Witzke
(b) Address 4101 Edmondson Ave

19 JAN 15 1945 (Date rec'd by registrar) (Signature for Williams M.D. Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1944 to Jan 11 1945 and that I last saw him alive on Jan 11 1945.

Immediate cause of death	Duration
Hemorrhage of the Brain	
Due to Arterio-Sclerosis & a previous Stroke	
Due to —	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas S Bowyer M. D.
Address Med Arts Bldg Date signed 1-12-45

VS 130

24701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 54B

G24701 Registered No.

70 #91093

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2028 Boyd St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Minnie Miller

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Robert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1888

8. AGE: Years	Months	Days	If less than one day
56	4	-5-	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name ? Arnold
13. Birthplace ?

MOTHER
14. Maiden Name Margaret ?
15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Jan 17 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Balto. Md

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave

JAN 15 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11, 1945, at 3:00PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12, 1944, to Jan. 11, 1945, and that I last saw her alive on Jan. 11, 1945.

	Duration
Immediate cause of death Brain tumor	
= Terminal bronchopneumonia	
Due to	
Due to	
Other Conditions Thrombosis of l. middle cerebral artery	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature C.A. Perry, D.
Address City Hosp. Date signed 1/12/45

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

24702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 582

Registered No. G24702

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 722 E 41st ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 116 E CLEMENT ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** MARY C. THUMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEM. | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JAN 31 - 1912

8. AGE: Years 32 | Months 11 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation HOUSE WORK

11. Industry or business AT HOME

FATHER 12. Name JOSEPH B. THUMAN

13. Birthplace BALTO MD

MOTHER 14. Maiden Name MARY HANEKE

15. Birthplace BALTO MD

16 (a) Informant FLORENCE THUMAN

(b) Address 116 E CLEMENT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 16-45 (month) (day) (year)

(c) Cemetery or crematory CATHEDRAL CEM

Location BALTO. MD

18 (a) Funeral director BERNARD C HARLE

(b) Address 121 E WEST ST.

19 (a) JAN 15 1945 (Date rec'd by registrar) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 13 1945 at 6:00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10, 1944 to 1-13-1945 and that I last saw her alive on 1-13-1945

Immediate cause of death: (a) Cer. Rheumatic fever — Duration: Childhood

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Geo B. Dyer M. D.

Address 2802 Harford Rd Date signed 1-15-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G24703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932

Registered No. G24703

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1238 Franklintown Road
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 79 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1238 Franklintown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Flanigan,

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Delia B. Flanigan,

6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Sept. 14. 1864

8. AGE: Years 80 | Months 4 | Days - | If less than one day hr. min.

9. Birthplace Ireland.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Dairy

FATHER
12. Name John Flanigan,
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine McLannin.
15. Birthplace Ireland.

16 (a) Informant Daniel J Flanigan,
(b) Address 1238 Franklintown Road,

17 (a) Burial (b) Date thereof Jan. 17. 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director George W. Little,
(b) Address 2700 Edmondson Ave.

19 JAN 15 1945 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 14 1945 19 . at 4A. M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1944 to Jan 14 1945, and that I last saw him alive on Jan 13 1945.

Immediate cause of death Cerebral Hemorrhage due to Hemiplegia

Duration 4 days

Due to Generalized arteriosclerosis arteriosclerotic type heart disease

Due to with cardiac enlargement and congestive failure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Mitchell M. D.

Address 2901 Edmondson Ave Date signed Jan 14 45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G24704 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th. St
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 5 7yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth M. Hackett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Nicholas R. Hacket

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14 1860

8. AGE: Years 84 | Months 11 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Charles Mc Makin
13. Birthplace Ellicott City Md.

MOTHER
14. Maiden Name Fannie Brickenridge
15. Birthplace Philadelphia

16 (a) Informant Home for Incurables
(b) Address 700 W. 40th St. Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 15 1945 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1945, at 6 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/35 1938, to 1/14/ 1945 and that I last saw h[illegible] alive on 1/12/ 1945

Immediate cause of death	Duration
Congestive Heart Failure	1 week
Due to Hypertensive Cardio-Vascular Disease	8 yrs.
Due to	
Other Conditions Hypertrophic Arthritis (Include pregnancy within 3 months of death)	18 yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Conway M.D.
Address 11 E. Chase St. Date signed 1/16/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

G24705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G24705

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Duvall Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Mc Burney Prager

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8 1901

8. AGE: Years	Months	Days	If less than one day
43	3	5	hr. min.

9. Birthplace Marietta Ohio
(Town, county, and state)
10. Usual Occupation Advertising Business
11. Industry or business

FATHER
12. Name Maurice Prager
13. Birthplace New York N.Y.

MOTHER
14. Maiden Name Hattie Hess
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Edward Prager
(b) Address 3408 Duvall Ave

17 (a) Burial (b) Date thereof 1/16/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Baltimore, Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (1-5-1945) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13, 1945, at 9:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw him alive on Jan. 13, 1945.

Immediate cause of death: Cardio-Respiratory Failure — Duration: 17 days

Due to: Subarachnoid Hemorrhage

Due to: Uraemia; Cardiac decompensation,

Due to: Hypertensive Cardio-Vascular-Renal Disease.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley H. Steinberg M.D.

Address Sinai Hospital Date signed 1/16/45

G24706

AB-91436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24706 Registered No. 1312

Please write plainly with pen or indelible pencil. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1546 McKean Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Marie Shipley (Marie Bertha Shipley)

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John W. Shipley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11-1916

8. AGE: Years 28 | Months 2 | Days 1 | If less than one day: hr. min.

9. Birthplace Maryland (Baltimore)
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Strob
13. Birthplace Md.

MOTHER
14. Maiden Name Ellen Minnick
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 1/16/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Dorsey, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) (Date received by Local Registrar) (b) Huntington Wills, M.D.

MEDICAL CERTIFICATION P

20. DATE OF DEATH Jan. 12- 1945, at 4.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4- 1945, to 1-12- 1945, and that I last saw h alive on 1-12- 1945.

Immediate cause of death Uremia — Duration ?

Due to Chronic pyelonephritis

Due to

Other Conditions lung abscess, arteriosclerosis, Kidneys, liver, spl. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Perry Jr. M.D.

Address City Hosp Date signed 1/13/45

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G24707 ✓ G21707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1705 N. Charles St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME WILLIAM GRICE BUNKLEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	213-03-8345

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Frieda W.(Geyer)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1876

8. AGE: Years	Months	Days	If less than one day
68	2	19	..... hr. ..... min.

9. Birthplace Isle of Wight Co., Va.
(Town, county, and state)
10. Usual Occupation Bartender
11. Industry or business

FATHER
12. Name William G. Bunkley
13. Birthplace Va.

MOTHER
14. Maiden Name Mary E. Grice
15. Birthplace Va.

16 (a) Informant Mrs. Frieda W. Bunkley
(b) Address 1705 N. Charles St.

17 (a) Removal (b) Date thereof 1/15/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory .....
Location Smithfield, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) ..... (b) Filed ..... Number .....
(Date received by registrar)

JAN 15 1945

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13, 1945, at 12:15PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10th 1944, to Jan 12th 1945, and that I last saw h[illegible] alive on Jan 12 1945.

Immediate cause of death Myocarditis

Due to Unknown. — Duration 6 months

Due to .....

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Wm Conrad Bode M. D.
Address 1900 Maryland Ave Date signed 1-13-45

X

24703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 16

G24708
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd & Herring Run
(c) Hospital or Institution: Sydenham Hosp. 6 W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 320 South Chapel
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Walter Leon Richardson, Jr.

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 214-16-6002

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife: —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 14, 1921

8. AGE: Years 23 yrs. Months 6 mos. Days 29 ds. If less than one day — hr. — min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Tin worker

11. Industry or business

FATHER
12. Name W. L. Richardson
13. Birthplace ?

MOTHER
14. Maiden Name Lillian Zielinski
15. Birthplace Baltimore

16 (a) Informant Mother
(b) Address 320 South Chapel

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Md.

18 (a) Funeral director George A. Weber,
(b) Address 705 E. Aisquith

19 JAN 15 1945 (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14 1945 at 5:[illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-8 1945 to 1-14 1945, and that I last saw h[illegible] alive on 1-14 1945

Immediate cause of death Respiratory failure — Duration —

Due to tuberculous meningitis — Duration —

Due to tubercle bacillus — Duration —

Other Conditions tuberculous epididymus, Pott's disease — Duration —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Margaret H. D. Steiner M. D.
Address Sydenham Hosp. Date signed 1-19-45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24709 FAIRMAN G24709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 203 N. allendale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 76 1/2 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 N. allendale St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) **FULL NAME** Elizabeth Jane Fairman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband ~~or wife~~ Frank W. Fairman

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) October 17 - 1867

8. AGE: Years 77 | Months 76 | Days 2 | If less than one day ..... hr. ..... min. | 27

9. Birthplace Wales
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Philip Webb
13. Birthplace Wales

MOTHER
14. Maiden Name ~~Unknown~~ Martha (Powell)
15. Birthplace Wales.

16 (a) Informant Frank W. Fairman
(b) Address 203 N. allendale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan - 16 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore Md.

18 (a) Funeral director Maurice Cohen
(b) Address 1600 W. North Ave

19 (a) JAN 15 1945 (Date rec'd by registrar) (b) Huntington Wilkinson Registrar

VS '150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 - 1945 at 1:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-14- 1944, to 1-13- 1945, and that I last saw h[er] alive on 1-12- 1945.

Immediate cause of death	Duration
Chronic Interstitial Nephritis	Unknown
Due to Hypertension	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chester Riland, M.D.
Address 2532 Edmondson Ave Date signed 1-13-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

24710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G24710

Registered No. 170 C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 20 Albemarle St.
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Annie Kozak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Alex. Kozak

6 (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) June 9 1890.

8. AGE: Years 54 55 | Months 1 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Louisa Charles
(b) Address Woodlawn Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 13 1945 (month) (day) (year)

(c) Cemetery or crematory St. Pauls. Reformed
Location Catonsville

18 (a) Funeral director Wendell J. Repsol
(b) Address 312 S. Stricker St.

19 JAN 15 1945 Date rec'd by registrar Wm. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1945, at 11:10 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock
Multiple fractures

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: S-1
(a) Date of injury 1-9-45 at 6:55 P. M.
(b) Where did injury occur? Fayette & High Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Pedestrian struck by Auto.

23. Signature Homer J. Madeira M.D.
Medical Examiner.
Date signed 1-10-45

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G24711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 129

Registered No. G24711

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hospital
(c) Hospital or institution: 2025 W Fayette St. Balto. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 56 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3901 York Rd. Balto. Md. (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Miss Agnes T. Hoen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ----------
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1888

8. AGE: Years	Months	Days	If less than one day
56	1	12	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -------

FATHER
12. Name George H. Hoen
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Joanna Carey
15. Birthplace Baltimore, Maryland

16 (a) Informant Miss Mary G. Hoen
(b) Address 1423 Winston Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director W. W. Mears and Son
(b) Address 805 N. Calvert Street

JAN 15 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION 45

20. DATE OF DEATH 1/12/1945, at 6-50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25/1944 to 1/12/1945 and that I last saw h-er alive on 1/12/1945

Immediate cause of death Pulmonary Embolism — Duration

Due to

Due to

Other Conditions Carcinoma Uterus 2 yrs — Hypothyroidism (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation Same

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Raymond Boyer M. D.
Address Bon Secours Hosp. Date signed 1/14/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G24712

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 169

Registered No. G24712

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2419 Huron Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Dorella Lee

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widow

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1869

8. AGE: Years	Months	Days	If less than one day
75	10	16	..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Augustus Bailey
13. Birthplace Md.

MOTHER
14. Maiden Name Christian Cook
15. Birthplace Md.

16 (a) Informant Mrs Christina Moore
(b) Address 2419 Huron St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JAN 15 1945 (Date rec'd by Registrar) (b) Livingston Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-12- 1945, at 11 50 A M

21. I certify that I took charge of the remains described above, held an Inspection - Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull
" 2nd & Cervical vertebra

Due to.....

Other Conditions Multiple fractures, lacerations abrasions & bruised bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 25/2
(a) Date of injury 1-12-45 at 11.35 A M.
(b) Where did injury occur? Annapolis ave: B&O.R.R.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by passenger R.R. Train

23. Signature Howard J. Mackelvain M.D.
Medical Examiner.
Date signed 1-12-45

G21713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1932

G21713 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 Division St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie Arvin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Richard Arvin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1872

8. AGE: Years	Months	Days	If less than one day
72	5	-	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Kester Wright
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Richard Arvin
(b) Address 1114 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JAN 15 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12, '45 19 , at 12:15 P

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to Jan 12 1945
and that I last saw [illegible] alive on Jan 12 1945

Immediate cause of death	Duration
(a) Apoplexy Cerebral	1 day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address [illegible] Date signed 1/13/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G24714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24714 Registered No. 1806

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1637 Bakelbury Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Bridgeporth

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/29/1943

8. AGE: Years 1 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Soloman Budgeforth
13. Birthplace Va

MOTHER
14. Maiden Name Polly Goldman
15. Birthplace Va

16 (a) Informant Solomon Budgeforth
(b) Address 1637 Bakelbury Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/45 (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location [illegible]

18 (a) Funeral director Geo. E. Nelson
(b) Address 1803 Pennsylvania Ave

19. (a) UNTSTR (Date rec'd by registrar) (b) Huntington Williams, M.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/21 1944 to 1/13 1945, and that I last saw h[illegible] alive on 1/13 1945.

Immediate cause of death Encephalitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell
Address Provident Hospital Date signed 1/14/45 (M.D.)

PHYSICIAN
Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

G24715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 d

Registered No. G24715

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 N. Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 N. Mount St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Green

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced. Widow.

6 (b) Name of husband or wife Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1858

8. AGE: Years 86 | Months 11 | Days - | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Thomas Cager
13. Birthplace Maryland

MOTHER
14. Maiden Name Lukenoon
15. Birthplace Maryland

16 (a) Informant Thomas Green
(b) Address 507 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Wes. H. Gilson
(b) Address 1803 Pennsylvania Ave (Huntington for Williamsport, Md)

19 (a) JAN 15 1945 (Date rec'd by local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1—13—1945 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1942 to Jan 13 1945, and that I last saw h[illegible] alive on 1-13-45 1945.

Immediate cause of death: Chronic Valvular Heart Disease — Duration: 2 yrs

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C. Page
Address 1816 N. Mount St (17) Date signed 1-15-45

VS 160

G24716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. G24716

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1760 E. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1760 East North Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY BELL RUTTER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Geo. W. Rutter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1869

8. AGE: Years	Months	Days	If less than one day
75	0	15	hr. min.

9. Birthplace Port Deposit, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Robert Tignor
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Virginia Schmidt
(b) Address 1730 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway
(c) Date received (month) (day) (year) (d) Huntington Williams M.D. Registrar

JAN 15 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13, 1945, at 12:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7, 1945 to Jan. 13, 1945; and that I last saw h[illegible] alive on Jan. 9, 1945

Immediate cause of death Cardio Respiratory Failure

Due to Carcinoma Esophagus

Due to

Other Conditions Cachexia Malnutrition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Davis, M. D.
Address 511 Med. Arts Bldg. Date signed Jan. 13, 1945

correct age is especially important. Physicians: please write the

VS 150

G24717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G24717

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Laynes Lubeland
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 E. Lanvale Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARRIE AGNES CORBIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Wm. H. Corbin
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1875

8. AGE: Years	Months	Days	If less than one day
69	1	22	hr. min.

9. Birthplace Woodstock, Va
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name St. Luke Racey
13. Birthplace Unknown

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mr. Elmer Lee Corbin
(b) Address 1708 Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1- 15-45 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial cem.
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address worth Ave. & Broadway

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

N 15145

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1945, at 7:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1945, to Jan 12 1945, and that I last saw h.e alive on Jan 12 1945.

Immediate cause of death Bronchial pneumonia

Due to

Due to

Other Conditions Congestive Heart failure
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ruth W. Boehmer M. D.
Address West Baltimore General Hosp. Date signed 1/12/45

G24718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

Registered No. G24718

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10d.
(e) Length of stay in Baltimore (yrs., mos., or days) 57

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 Aldolfston St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: AMELIA AMY DITTUS

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: O.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Apr. 2 1887.
8. AGE: Years 57 Months 9 Days 8 If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name William G Dittus
13. Birthplace Md

MOTHER
14. Maiden Name Fannie B Hatchel
15. Birthplace Md

16 (a) Informant Mrs. Charles Zimmerman
(b) Address 2514 Harford Rd. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

JAN 15 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1945 at 11.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Jan 11 1945 and that I last saw her alive on Jan 11 1945

Immediate cause of death	Duration
Carcinoma	
Due to Carcinomatosis	
Due to	
Other Conditions Rheumatic Heart disease (Include pregnancy within 3 months of death)	

Date of operation 1-9-45
Major findings of operation: Generalized abdominal carcinomatosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elelijah Epragius M. D.
Address Union Memorial Hosp Date signed 1-12-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G24719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V137a

G24719

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1600 N. Caroline St
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 316 Wonsley St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis Louis Wiley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31 1879

8. AGE: Years 65 66 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Md

MOTHER 14. Maiden Name Eliza Stewart

15. Birthplace Md

16 (a) Informant Charles Johnson

(b) Address 316 Wordsley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 15 45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A-2 40

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E. Preston St

19 1 5 1945 (b) Huntington Williams, M.D. Registrar

(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1945, at 7:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1945, to Jan 10 1945, and that I last saw alive on Jan 10 1945.

Immediate cause of death Duration

Uremia

Due to Prostatic Obstruction over

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A M Bacon Jr M. D.

Address St Josephs Hospital Date signed 1-10-45

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24720 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: Univ Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hr
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5335 Denmore Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Thomas Butler

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	married

6 (b) Name of husband ~~or wife~~ Ebsworth Butler
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 12 - 45 1907

8. AGE: Years	Months	Days	If less than one day
38	-	-	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife & Domest Work
11. Industry or business Domestic Work

FATHER
12. Name ~~Thos.~~ Jacob Thomas
13. Birthplace md.

MOTHER
14. Maiden Name Dolcie Brown Thomas
15. Birthplace md.

16 (a) Informant Husb
(b) Address 5335 Denmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17, 1945 (month) (day) (year)
(c) Cemetery or crematory Bal. Calvary
Location Baltimore Md

18 (a) Funeral director Wm Lew. W. Holland
(b) Address 1915 Druid Hill Ave

(Date rec'd by registrar) JAN 13 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12 1945 at 7.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12 PM 1945 to 1-12 1945, and that I last saw h~~e~~r alive on 1-12 1945.

Immediate cause of death	Duration
Respiratory Paralysis	
Due to Cardio Vascular Dis.	
Due to Marked Obesity	
Other Conditions Pluro glandular syndrome	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation: none
of autopsy: Obesity Enlarged Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Tankhouser M.D. M. D.
Address Univ. Hosp Date signed 1-12-45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

Registered No. G24721

Type or print all causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Lindsay

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C.	Married

6 (b) Name of husband or wife Richard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1918

8. AGE: Years	Months	Days	If less than one day
26	6	29	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry C. Blackwell
13. Birthplace Crew, Va

MOTHER
14. Maiden Name Mary Knight
15. Birthplace Crew Va

16 (a) Informant Richard Lindsay
(b) Address 1511 Madison Av.

17 (a) Burial (b) Date thereof Jan. 17, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lew. A. Hallard
(b) Address 1649 Druid Hill Av.

19 JAN 15 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13 1945, at 3 05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute nephritis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Jan. 14 1945

VS 151

G24722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G24722 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 307 Dolphin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 Dolphin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Jones
3 (b) If veteran, name war (c) Social Security Account No.

4 Sex: male | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife Fannie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 6, 1887
8. AGE: Years 67 | Months 5 | Days 7 | If less than one day: hr. 18 min. 7
9. Birthplace Luenburg Va (Town, county and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name William Jennings
13. Birthplace Luenburg, Va

MOTHER
14. Maiden Name Laura ?
15. Birthplace Va

16 (a) Informant Fannie Jones
(b) Address 307 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 16, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.
18 (a) Funeral director Mrs. Lee V. Hartman
(b) Address 1631 Druid Hill Ave.
19 (a) JAN 15 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 45

20. DATE OF DEATH 1/13 1945, at 12 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/6 1945 to 1/13 1945; and that I last saw him alive on 1/12/1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 6 days
Due to
Due to Hypertensive — 1 month
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hawkesworth M.D.
Address 1131 Harlem Ave Date signed 1/15/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G24723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1176 Registered No. G24723

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 723 N. Luzerne
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Rafferty
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1908

8. AGE: Years 36 | Months - | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Orderly

11. Industry or business Johns Hopkins Hosp.

FATHER
12. Name James Rafferty
13. Birthplace York, Pa.

MOTHER
14. Maiden Name Anna Goth
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Emma Hughes (sister)
(b) Address JOHNS HOPKINS HOSPITAL 723 N. Luzerne Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

JAN 15 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1945, at 5:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to Jan 10 1945 and that I last saw him alive on Jan 10 1945.

Immediate cause of death: Respiratory failure — Duration: 1 day

Due to: Coronary cardiac & pulmonary disease & pneumothorax, spontaneous, & tuberculosis, pulmonary, chronic, minimal — Duration: 4 yrs.

Due to: stenosis & mitral insufficiency — Duration: 4 yrs.

Due to: Emphysema, chronic, right & old — Duration: 4 yrs.

Other Conditions: Encapsulated, right — Duration: 1 yr.

Duodenal ulcer
(Include pregnancy within 3 months of death)

Date of operation 1941, 1942

Major findings of operation: Emphysema, chronic, right, due to pneumothorax

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham Cohen M. D.
Address Johns Hopkins Hosp. Date signed 1-10-45

VS 150

95B

G24724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. G24724

1. PLACE OF DEATH: 629 N. Carrollton Ave
(a) Baltimore City, Maryland Baltimore Md
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(c) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 N Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Fenn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Robert Fenn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24 1906

8. AGE: Years 38 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace Clover, Va
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Sherrod Coleman
13. Birthplace Clover, Va

MOTHER
14. Maiden Name Mary Stroud
15. Birthplace Clover, Va.

16 (a) Informant Jeanie Franklin
(b) Address 728 N. Carrollton Ave

17 (a) Burial (b) Date thereof Jan 15 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Clover Va
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

JAN 15 1945 Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1945 at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1944, to Jan 12 1945
and that I last saw h alive on 1/11 1945.

Immediate cause of death Carcinoma of Cervix Uteri
Bladder & Rectum

Duration 8 mo

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature B. F. Hatchett M. D.
Address 1725 Park Ave Date signed 1/13/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C24725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C24725

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1814 Asquith St.
(c) Hospital or institution: ********
(d) Length of stay in hospital or inst. (yrs., mos., or days) **
(e) Length of stay in Baltimore (yrs., mos., or days) Life

9-9

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 Asquith St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude A Baker

3 (b) If veteran, name war ****
3 (c) Social Security Account No. ********

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1877

8. AGE: Years 67 | Months 9 | Days 27 | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Robert Hollandshade
13. Birthplace: Baltimore Md

MOTHER
14. Maiden Name: Alberta Hunt
15. Birthplace: Baltimore Md

16 (a) Informant: Harry Baker (Husband)
(b) Address: 1814 Asquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/45 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Baltimore Co Parkville

18 (a) Funeral director: J Melville Jenkins
(b) Address: 2713 Kirk Ave

JAN 15 1945 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 — 13 — 1945, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 8 1944, to 1-12 1945, and that I last saw h[er] alive on 1/12 1945.

Immediate cause of death: Ch myocarditis.
Due to: ch arteriosclerosis
Due to: ch nephritis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. H. Hornstein M. D.
Address 733 Argyle St Date signed 1/15/45

G24726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G24726

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 O'Donnell Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Willard Morgan~~ Willard Thomas Morgan

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-2180

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Lula Morgan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1904

8. AGE: Years 40 ~~41~~ | Months 6 7 | Days 7 | If less than one day hr. min.

9. Birthplace Seaford, Delaware (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name ~~Harry Morgan~~

13. Birthplace ~~Unknown~~ Seaford, Del.

MOTHER 14. Maiden Name ~~Minnie Hare~~ Minnie E. Hare

15. Birthplace Seaford, Delaware

16 (a) Informant ~~Minnie Trimpe~~ Mrs. Minnie Trimpe

(b) Address 4823 Pennington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 17, 1945 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cemetery

Location Anne Arundel County, Md.

18 (a) Funeral director Wilkie Lamotte

(b) Address 1003 W. Baltimore St.

JAN 15 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/13 1945 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/12 1945 to 1/13 1945; and that I last saw h[illegible] alive on 1/13 1945.

Immediate cause of death: Cerebro-meningeal hemorrhage, accidental (clinical diagnosis) — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: No cause of death found

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Carl Myers, M. D.

Address Franklin Sq. Hosp. Date signed 1/14/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Omission of information should be carefully supplied.

G24727

G24727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5145 Frederick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5145 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willard W. Kirwan

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-5157

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Laura L. Kirwan

6 (c) If wife, give age 61 years

7. Birth date of deceased (mo., day, yr.) Oct. 26 1881

8. AGE: Years 63 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Advertising - Trade up hour

11. Industry or business Baltimore - News-American

FATHER 12. Name Theodore Kirwan
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Annie Brown WOMN
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Laura L. Kirwan
(b) Address 5145 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 16 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Baltimore Md.

18 (a) Funeral director Phillips Lamborn
(b) Address 4510 Liberty Heights Ave

19 (a) Filed JAN 15 1945 (b) Registrar Arthur Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 13 1945, at 3:50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1944 to Jan 13 1945, and that I last saw h[illegible] alive on Jan 13 1945.

Immediate cause of death: Cardio-myocarditis — Duration: 6 mos

Due to:

Due to:

Other Conditions: Arteriosclerosis — 3 yrs

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John H. Evans M. D.

Address 617 N. 40th St Date signed

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G24728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 14

G24728

Registered No.

The information should be carefully supplied. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 7822 Oakleigh Rd.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin Hughes

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mary Jane Hughes

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) June 27, 1900

8. AGE: Years	Months	Days	If less than one day
44	6	17	— hr. ... min.

9. Birthplace Pennsylvania (town, county, and state)

10. Usual Occupation Bricklayer

11. Industry or business —

FATHER 12. Name Robert Hughes

13. Birthplace Wales

MOTHER 14. Maiden Name Elizabeth A Lloyd

15. Birthplace Wales

16 (a) Informant Mrs. Mary Jane Hughes

(b) Address 7822 Oakleigh Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-45 (month) (day) (year)

(c) Cemetery or crematory Maryland

Location Baltimore

18 (a) Funeral director George J. Ruck

(b) Address 5309 Harford Rd.

19 (a) ... (Date rec'd by registrar) (b) Huntington Wilkinson, M.D. Registrar

JAN 15 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945 at 1:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/12 1945 to 1/13 1945 and that I last saw h[illegible] alive on 1/13 1945

Immediate cause of death	Duration
Cerebro Spinal Fever	
Due to Meningitis (T.B.)	2 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature C. F. Holdsworth M. D.

Address Mercy Hosp. Date signed 1/13/45

X

G24729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

G24729 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Elkridge Md.
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 5418 Main St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Dona Lee Tipton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/5/44

8. AGE: Years | Months | Days: 10 | If less than one day: hr. min.

9. Birthplace Elkridge, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER | 12. Name Lloyd Tipton

13. Birthplace Va.

MOTHER | 14. Maiden Name M. Gladys Whitten

15. Birthplace Md

16 (a) Informant Hospital Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 15-1945 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cemetery

Location Elkridge Md

18 (a) Funeral director D. Foster Carter

(b) Address Ellicott City, Md

JAN 15 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15 1945, at 2:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9 1945, to 1/15 1945, and that I last saw h.CT. alive on 1/15 1945.

Immediate cause of death: Respiratory failure — Duration: 6 hrs

Due to:

Due to: Congenital atresia of oesophagus — 4 days

Other Conditions: Oesophageal tracheal fistula

(Include pregnancy within 3 months of death)

Date of operation 1/11/45

Major findings of operation: Atresia of oesophagus & trachea-oesophageal fistula

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen A Howe M. D.

Address University Hosp Date signed 1/15/45

cerect age is especially important. Physicians: please write the causes of death clearly and legibly.

G24730

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1107

G24730 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1229 Myrtle Ave.
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1229 Myrtle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irene Tolson Curry

3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex F.
5. Color or race Negro
6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Thomas Curry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-17-98

8. AGE: Years 46 | Months 6 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Heathsville, Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Zephiniae Pryor
13. Birthplace Va.

MOTHER
14. Maiden Name Jannie Curry
15. Birthplace Va.

16 (a) Informant Jennie Tolson Spencer
(b) Address 1229 Myrtle Ave.

17 (a) Burial (b) Date thereof 1-17-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Heathsville Va

18 (a) Funeral director Charles R. Lawson
(b) Address 807 Madison Ave.

19 (a) ... (b) ...
(Date received by Registrar) Registrar

JAN 15 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14 1945, at 5:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1945 to Jan 14 1945, and that I last saw h[illegible] alive on Jan 14 1945.

Immediate cause of death — Duration

Due to Acute Dilatation of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Woodland
Address 861 Hanlon Date signed 1/15/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

G24731 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 843 W. Franklin St.
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 843 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charity Monroe

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F.

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Isaac Gamble

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-7-93

8. AGE: Years 51 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Fayetteville, N. C.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Henry Monroe
13. Birthplace N. C.

MOTHER
14. Maiden Name Easter Monroe
15. Birthplace N. C.

16 (a) Informant Irving Monroe
(b) Address 843 W. Franklin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-45 (month) (day) (year)
(c) Cemetery or crematory New Hope Cem.
Location Fayetteville N. C.

18 (a) Funeral director Charles R. Law
(b) Address 802 Mad. Ave.

19 (a) JAN 15 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/13/45 19 , at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 19 45 to 1/13/45 and that I last saw h alive on 1/12/45

Immediate cause of death — Duration

Due to Cerebral hemorrhage

Due to Arteriosclerosis

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Cook Coons M. D.

Address 1131 Harlem Date signed 1/15/45

G24732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G24732 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4408 Ivanhoe Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4408 Ivanhoe Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Isabel Clarke

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~
Female	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20 1864

8. AGE: Years	Months	Days	If less than one day
80	2	19 24	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name John T Kane
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Annie O'Neill
15. Birthplace Ireland

16 (a) Informant Florence E. Clarke
(b) Address 4408 Ivanhoe Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 16-45 (month) (day) (year)
(c) Cemetery or crematory Woodland Park
Location Balto. Md

18 (a) Funeral director John C Moran
(b) Address 3209 Huntington Ave Baltimore, Md

19 (a) (b) (Date received by registrar) Registrar

JAN 15 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 1945 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1945 to Jan 13 1945 and that I last saw her alive on Jan 11 1945

Immediate cause of death	Duration
Myocarditis	2 yrs
Due to Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. N. Pearce M. D.
Address 2105 Charles Date signed Jan 16 1945

G24733 Eckels G24733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1570

Registered No.

Every item of information should be carefully written; PRINTING UNNECESSARY. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1619 Bovington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Bovington
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Donna E Eckels

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1944

8. AGE: Years | Months 7 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William B Eckels
13. Birthplace Balto Md

MOTHER
14. Maiden Name Anna H. Jones
15. Birthplace 1619 Bovington Md

16 (a) Informant William B Eckels
(b) Address 1619 Bovington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore Md

18 (a) Funeral director C. Howard Evans
(b) Address 1400 S. Charles St

19 (a) ... (b) Huntington Willis Registrar

JAN 15 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 14 1945, 1250 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1944 to Jan 14 1945 and that I last saw h[illegible] alive on Jan 14 1945.

Immediate cause of death Bronchio-pneumonia (Terminal)
Due to
Due to
Other Conditions Spina-bifida - Hydrocephalus.
(Include pregnancy within 3 months of death)

Duration

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Schemmel
Address 1337 S. Charles St Date signed 1/15/45 M. D.

G24734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G24734

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 807 Shuter
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 Shuter (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Gladys Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1944

8. AGE: Years	Months	Days	If less than one day
	5	13	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Elvin Williams
13. Birthplace Oxford N. C.

MOTHER
14. Maiden Name Margaret Teagle
15. Birthplace Roanoke City (Va)

16 (a) Informant Elmer Williams
(b) Address 807 Shuter

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Robert L. Crumb

18 (a) Funeral director 804 W. Fairmount Ave
(b) Address

19 (a) JAN 13 1945 (Date received by registrar) (b) Registrar

Vs: Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1·14 1945, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1·13 1945 to 1·14 1945, and that I last saw he alive on 1·14 1945.

Immediate cause of death	Duration
Bronchopneumonia	1 day
Due to	3 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury
23. Signature Wm. J. Roy Berry M. D.
Address 1420 E. Chase Date signed 1-14-45

M. D. B. 1268-9

G24735

G24735 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH ✓ 93D

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2617 Fait Ave. | 1-4 St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Stanislawa Kaczorowski

(a) Residence: No. 2617 Fait Ave. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Martin Kaczorowski

6. DATE OF BIRTH (month, day, year) 1876

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
69	68			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Poland

FATHER

13. NAME Andrew Spis

14. BIRTHPLACE (city or town) (State or country) Poland

MOTHER

15. MAIDEN NAME ? Staniszewski

16. BIRTHPLACE (city or town) (State or country) Poland

17. INFORMANT Mrs. Pelagia Szymanski
(Address) 2617 Fait Ave.

18. BURIAL, CREMATION, OR REMOVAL
Place St Stanislaus Date Jan 16 1945

19. UNDERTAKER John M Peters
(Address) 401 S. Chelsea Rd Huntington Williams, Md.

20. FILED JAN 15 1945 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan. 12 1945

22. I HEREBY CERTIFY, That I attended deceased from April, 1944, to Jan 12, 1945
I last saw h or alive on Jan 12, 1945 Death is said to have occurred on the date stated above, at 6:45 pm

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic myocarditis.	unk

Other contributory causes of importance:

arteriosclerosis.	unk

Name of operation ✓ Date of ✓

What test confirmed diagnosis? ✓ Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ✓ Date of injury ✓, 19

Where did injury occur? ✓
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ✓

Manner of injury ✓

Nature of injury ✓

24. Was disease or injury in any way related to occupation of deceased? ✓
If so, specify

(Signed) Frank Januszewski M. D.

(Address) 2617 Fait Ave

V. S. OCCUPATION is very important. See instructions on back of certificate.

G24736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

G24736 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 609 E. Chapel Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 609 E. Chapel street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Stella Lijewski LIJEWSKI

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife Stanislaus Lijewski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11 1865

8. AGE: Years	Months	Days	If less than one day
79	8	1	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Chmielewski
13. Birthplace Poland

MOTHER
14. Maiden Name Josephine ?
15. Birthplace Poland

16 (a) Informant Mrs Anna Messick
(b) Address 2118 Bank Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore County

18 (a) Funeral director John M. Welby
(b) Address 401 S. Chester St

JAN 15 1945 (b) Date rec'd by registrar

Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-12- 1945, at 11 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating Gas

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-12-45 at 2/3 P. M.
(b) Where did injury occur? 609 E. Chapel St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Left open on gas range

23. Signature Thomas J. Mallezis M.D.
Medical Examiner.
Date signed 1-13-45

Dr. Golly
5100 Bk. Harford C24737

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2908 Northern Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Northern Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Thager Mariner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Stanwood C. Mariner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1866

8. AGE: Years 78 | Months 2 | Days 10 | If less than one day: hr. min.

9. Birthplace Portland, Maine
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknwon
15. Birthplace unknown

16 (a) Informant Mr. Robert D. Mariner
(b) Address 2908 Northern Parkway (14)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/ /45 (month) (day) (year)
(c) Cemetery or crematory
Location Portland, Maine

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road (14)

JAN 15 1945 (a) [illegible] (b) Huntington Williams M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1939 to 1/13 1945, and that I last saw h[illegible] alive on 1/13 1945.

Immediate cause of death Chronic Myocarditis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Myles J. Golly M. D.
Address 5703 Harford Rd Date signed 1/17/45

X

Please write the causes of death clearly and legibly. Physicians: please write carefully supplied information should be especially important. Exact age is especially important.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G24738 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Howard
(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)
(d) Street No. R F D. 2 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Miss Elsie Elliott

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 2, 1888
8. AGE: Years 56 Months 10 Days 12 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Household duties
11. Industry or business

FATHER
12. Name William D. Elliott
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Jones
15. Birthplace Maryland

16 (a) Informant Miss Mary C. Elliott
(b) Address Ellicott City, Md. R.F.D. #1

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 16, 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.
(c) Filed [illegible] By Registrar (b) [illegible]

JAN 15 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14/45 19 10:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7 1945, to 1/14 1945, and that I last saw h[illegible] alive on 1/14 1945.

Immediate cause of death: Respiratory Failure — Duration

Due to: massive pulmonary Infarction

Due to: Thrombophlebitis of Rt Common Iliac vein

Other Conditions: Adeno carcinoma of Rt ovary

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Service as relevant

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cluff Rowett M. D.
Address St Agnes Hosp Date signed 1/17/45

100b

G24739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24739 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 402 Gittings Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Gittings Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY J. MERCERON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Marie McDonald
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1889

8. AGE: Years	Months	Days	If less than one day
56	0	12	hr. min.

9. Birthplace Carroll Co., Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Frank G. Merceron
13. Birthplace Baltimore Co., Md.

MOTHER
14. Maiden Name Mary D. Wright
15. Birthplace Baltimore Co., Md.

16 (a) Informant Mrs. George F. Anderson
(b) Address 402 Gittings Ave. Govans.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/45 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Md.

18 (a) Funeral director H. W. Meamston
(b) Address 805 N. Calvert St.

19 (a) Date received JAN 1 6 1945 (b) Registrar Huntington Williams M.D.
VS 116

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1945, at 9 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 9th 1944 to January 14th 1945 and that I last saw him alive on Jan 13th 1945

Immediate cause of death	Duration
Myocarditis Chronic.	4 years. unknown
Due to —	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ad. Chaffant M. D.
Address 6811 York Rd Date signed Jan 15, 45

G24740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G24740

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1230 E. North Ave
(c) Hospital or institution: 41
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 89 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1230 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis H Lentz

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1856

8. AGE: Years	Months	Days	If less than one day
90 89	—	—	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business Baber

FATHER
12. Name Hredinch L. Lentz
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Brandt
15. Birthplace Germany

16 (a) Informant Miss Irene Lentz Daughter
(b) Address 1230 E. North Ave

17 (a) Burial (b) Date thereof 1-17-1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral Cemetery
Location —

18 (a) Funeral director Mary M Wiedefeld
(b) Address 201 E. 22nd St

JAN 16 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 14th 1945, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 29 1944 to Jan. 14 1945, and that I last saw h / Malive on Jan 14 1945

Immediate cause of death Arteriosclerotic Cardiac - Duration ?
Vascular Nephritis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Blum M.D.

Address 1206 E. Preston St Date signed 1/14/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G24741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. 91155

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Degener

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1870 ??

8. AGE: Years 74 ???? Months 5 Days If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Christian
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Germany

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS).

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Towsontown Md

18 (a) Funeral director Gilbert Undertaking Co
(b) Address 217 N. Carey St.

19 (a) 1-16-1945 (Date rec'd by Registrar) Gilbert for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15, 1945, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-16- 1944, to 1-15- 1945, and that I last saw him alive on 1-15- 1945.

Immediate cause of death Uremia — Duration ?

Due to Nephrosclerosis

Due to

Other Conditions Hypertensive Heart Disease ?
Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Balto. Md. Date signed 1-15-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

24742 ✓ G24742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92C Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3902 W. Hadley Square
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 Hadley Square (West) (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Lee Cecelia Bennett

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband Alton M. Bennett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 15th 1903

8. AGE: Years 41 | Months 10 | Days 16 | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name " Mirdjanowski
13. Birthplace Austria

MOTHER
14. Maiden Name Wanda "
15. Birthplace "

16 (a) Informant Dr. Alton M. Bennett
(b) Address 3902 Hadley Square West

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 JAN 16 1945 (Date rec'd by registrar) Interior for Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1944 to Jan 15 1945, and that I last saw h alive on 19

Immediate cause of death	Duration
Oedema of lungs	3 days
Due to Endocarditis with Mitral Stenosis Rheumatic	
Due to dilatation due to Myocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Gerstenfeld M. D.
Address 3201 Garrison Blvd Date signed Jan 15th 45

correct ago is especially important. Physicians: please write the causes of death clearly and legibly.

G24713 ✓ G24713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

930 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3224 E. Lombard st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3224 E. Lombard st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Koutz

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	220-07-7747

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Eva B. Koutz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26th 1875

8. AGE: Years	Months	Days	If less than one day
69	8	17	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Penn Jones G.

FATHER
12. Name Fleetwood Koutz
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Avaison
15. Birthplace Balto. Md.

16 (a) Informant Eva Koutz
(b) Address 3224 E. Lombard st.

17 (a) Burial (b) Date thereof 1/17/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Extended

18 (a) Funeral director William Cook Inc
(b) Address 127 S. Paul st

19 JAN 16 1945 H. Livingston for Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13th 1945, at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8/45 19 to 1/13 1945.
and that I last saw him alive on 1/13 1945.

Immediate cause of death Cardiac failure

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
2 months
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard A. Thomas M.D.
Address 333 S. Ecclston Date signed 1/15/45

correct age is especially important. Physicians: please write the

VS 180

+ Married

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G21734

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1829 Aisquith St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Baumgardt Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie T. Fuchs / Fuchs

3 (b) If veteran, name war	3 (c) Social Security Account No.
NV	none

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	W	Widowed

6 (b) Name of husband ~~or wife~~ John T. Fuchs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13 1880

8. AGE: Years	Months	Days	If less than one day
64	8	1	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Joseph H. Daly
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma Myers
15. Birthplace Balto. Md.

16 (a) Informant Mrs Matilda Middleton
(b) Address 829 Aisquith St.

17 (a) Burial (b) Date thereof 1-17-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Oak Lawn
Location Eastern Ave - Extended

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St. Paul St.

19 JAN 16 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14 1945, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Chester F. Tulowitzki M.D.
Medical Examiner.
Date signed 1/17/45

VS 151

24715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24715 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital - D.O.H. 5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 285 Exeter St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry McFarland

3 (b) If veteran, name war: NA
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 1869

8. AGE: Years 75 | Months 4 | Days | If less than one day ... hr. ... min.

9. Birthplace Pa (Town, county, and state)
10. Usual Occupation Weigh Loyd
11. Industry or business

FATHER
12. Name George McFarland
13. Birthplace Pa

MOTHER
14. Maiden Name Rose Haviland
15. Birthplace Md.

16 (a) Informant Maurice McFarland
(b) Address 1617 Lamont Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1/17/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville, Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

JAN 16 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14 1945, at 2:10 M.

21. I certify that I took charge of the remains described above, held an Autopsy - Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Charles L. Nelson M.D. Medical Examiner.
Date signed 1/17/45

VS 151

24716 ✓ G24716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caldwell & Saratoga
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 W. Mulberry
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME MARY E. BEVAN

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 10th 1881

8. AGE: Years	Months	Days	If less than one day
63	9	3	..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Typist
11. Industry or business Internal Revenue Dept

FATHER
12. Name Nicholas K. Bevan
13. Birthplace Md.

MOTHER
14. Maiden Name Mary N. McCafferty
15. Birthplace Pa.

16 (a) Informant Grace C. Troxler
(b) Address 1729 St. Paul St

17 (a) Burial (b) Date thereof 1/17/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 JAN 16 1945 (b) Huntington Williams, M.D.
Registered by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13, 1945, at 8:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema
Arteriosclerotic Cardiovascular Disease

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature John L. Davis, M.D.
Medical Examiner.
Date signed Jan. 14, 1945

VS 151

G24727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G24727

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1813 McCulloh St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 McCulloh (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Samuel James Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1864

8. AGE: Years 80 | Months 1 | Days 2 | If less than one day hr. min.

9. Birthplace Balto. Co. Md. (City, county, and state)

10. Usual Occupation Steward

11. Industry or business

FATHER
12. Name Samuel Smith
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Elizabeth Myers
15. Birthplace Balto. Co. Md.

16 (a) Informant James Smith
(b) Address 1813 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Wm. Jas. H. Holland
(b) Address 1608 Druid Hill Ave.

19 (a) (b) Registrar Huntington Williams, M.D.

JAN 16 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11-1945, at 5:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-12-1944 to 1-11-1945, and that I last saw him alive on 1-5-1945.

Immediate cause of death	Duration
Arteriosclerosis	
Due to Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell M. D.
Address 718 Dolphin St. Date signed 1-15-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24748 G24748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 11F486

Please write the causes of death clearly and legibly. Physicians: please write the cause of death in the following space. Be sure that the information given is correct as it is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Emmitsburg
(If outside city or town limits write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary O'Donoghue

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	

6 (b) Name of husband or wife: $
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1858

8. AGE: Years	Months	Days	If less than one day
87			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 1/18/45 (month) (day) (year)
(c) Cemetery or crematory St Anthonys R.C.
Location Frederick Co.

18 (a) Funeral director D. L. Allison
(b) Address Emmitsburg, Md.

19 JAN 16 1945 (Date received by local registrar) (b) Huntington, Washington, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15-1945, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6-1945 to 1-15-1945, and that I last saw h.e.r. alive on 1-13-1945.

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Hemorrhage	
Due to Arteriosclerotic Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. F. Carr Jr. M.D.
Address St. Agnes Hosp. Date signed 1/16/45

G24749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24749 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3211 Echo Dale Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 76 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 Harford Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa K. Hauser

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) May 3rd, 1866

8. AGE: Years 78 | Months 8 | Days 18 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George F. Hauser
13. Birthplace Germany

MOTHER
14. Maiden Name Rebecca Amrein
15. Birthplace Baltimore County

16 (a) Informant Mrs. Frederick Horn
(b) Address 1704 E. Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Ave., Balto: Md

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 JAN 16 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 14 1944 to Jan. 15 1945, and that I last saw h[illegible] alive on Jan. 8 1945.

Immediate cause of death: Coronary Thrombosis — Duration: Died

Due to: Arteriosclerotic Cardiac Disease ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jacques S. Bloom M.D.
Address 1206 E. Monument St. Date signed 1/15/45

G24730 G24730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1700

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 Hr.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 1002 E. Hoffman St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George E. Harp George Edward Harp

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: M.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lula G. Ernest
6 (c) If alive, give age 53 years
7. Birth date of deceased (mo., day, yr.) March 22, 1875
8. AGE: Years 69 | Months 9 | Days 22 | If less than one day ____hr. ____min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired, Painter
11. Industry or business

FATHER
12. Name William Harp
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Taylor
15. Birthplace Maryland

16 (a) Informant Mrs. Lula G. Harp (Wife)
(b) Address 1002 E. Hoffman Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 17, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) JAN 16 1945 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14 1945, at 12:30 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Skull fracture
Fractured Lt. ribs 5-10
Due to Fractured Lt. lower leg
Coronary thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Jan. 12 1945 11:45 P.M.
(b) Where did injury occur? Union & Pratt Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Edward E. Miller M.D. Medical Examiner.
Date signed 1-14-45

24751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46D

Registered No. G24751

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1704 N. Gont St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 N. Gont St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Rankin Bull

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-4394

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Barbara Bull

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Jan - 17 - 1883

8. AGE: Years 61 | Months 11 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Brewery

FATHER
12. Name James Bull
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Geralding Farnbaugh
15. Birthplace Carleton Md

16 (a) Informant Barbara Bull
(b) Address 1704 N. Gont St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 - 18 - 45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Balto Md

18 (a) Funeral director Guy L. Miller Inc
(b) Address 2425 E. Oliver St.

JAN 16 1945 Huntington Williams M.D. Registrar
(Date received by local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 14 - 1945, at 2.25 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1944 to 1/14 1945 and that I last saw h[illegible] alive on 1/13 1945.

Immediate cause of death — Duration

Carcinoma of rectum — 1½ yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Max Baer M. D.
Address 1501 W. Wilson Ave Date signed 1/14/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G24752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G24752

1. PLACE OF DEATH:
(a) Baltimore City, Maryland DOA
(b) Street address 2317 W. Lexington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2317 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H Henneman

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-6671

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 22, 1890

8. AGE: Years 54 | Months 4 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Packer

11. Industry or business Muth Bros. Drugs,

FATHER
12. Name John H. Henneman,
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Rosalie Mahn,
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Frances E. Pearce,
(b) Address 2317 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 18, 1945 (month) (day) (year)
(c) Cemetery or crematory LOudon Park
Location Baltimore Md.

18 (a) Funeral director George W. Little,
(b) Address 2700 Edmondson Ave.

19 (a) JAN 16 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15 19 45, at 9:45 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry, and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Charles F. Sabin M.D. Medical Examiner.
Date signed 1/15/45

G24753 | BALTIMORE CITY HEALTH DEPARTMENT | G24753

CERTIFICATE OF DEATH

93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1601 Sexton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 Sexton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward L Harman

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-9497

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Emma Harman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 - 1886

8. AGE: Years 58 | Months 10 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Night Watchman

11. Industry or business Wentworth Asb

FATHER 12. Name Edward L Harman

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Rosa Wagner

15. Birthplace Baltimore and

16 (a) Informant Emma Harman

(b) Address 1601 Sexton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 16-45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem

Location

18 (a) Funeral director Chas P Towell

(b) Address 427 Edmondson Ave

JAN 16 1945 (Date received by local registrar) (b) Huntington Williams, M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1945, at 11.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1943, to Jan 1945, and that I last saw him alive on Jan. 11 1945.

Immediate cause of death Coronary Thrombosis — Duration

Due to Arteriosclerotic C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Yes of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John C. Pound M. D.

Address 400 N. Payson Date signed 1/15/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

24754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G24754

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 402 E. Gittings Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 E. Gittings Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. FRED ANDERSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Laura Herring Anderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1865

8. AGE: Years	Months	Days	If less than one day
79	4	17	hr. min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)
10. Usual Occupation STATION MASTER
11. Industry or business P.R.R. - Retired

FATHER
12. Name John S. Anderson
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Elizabeth Cadwalader
15. Birthplace Ohio

16 (a) Informant Mr. Steuart Anderson
(b) Address 200 St. Dunstans Rd.

17 (a) Burial (b) Date thereof 1/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Taylor's Chapel Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 16 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14, 1945 at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1945, to Jan 14 1945, and that I last saw h in alive on Jan 14 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	6 hours
Due to Arteriosclerosis	10 years
Due to	
Other Conditions Hypertension	16 years.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature A. S. Chalfant
Address 6210 York Rd Date signed Jan 15, 45 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G24755

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2831 Guilford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2831 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Ira Tubman Croswell

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	212-03-5554

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mamie Scherf Croswell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1881

8. AGE: Years	Months	Days	If less than one day
63	3	20	hr. min.

9. Birthplace Oriole Somerset Co., Md.
(Town, county, and state)
10. Usual Occupation Sect. & Treas.
11. Industry or business Building Contractors

FATHER
12. Name Severn Tyler Croswell
13. Birthplace Somerset Co. Md.

MOTHER
14. Maiden Name Mary Follin
15. Birthplace Somerset Co. Md.

16 (a) Informant Miss Dorothy Croswell
(b) Address 2831 Guilford Ave.

17 (a) Burial (b) Date thereof 1/16/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 JAN 16 1945 Huntington Nelligan M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14th 1945, at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945, to Jan 14 1945; and that I last saw h[illegible] alive on Jan 1 1945

Immediate cause of death	Duration
Coronary occlusion	?
Due to Chronic arteriosclerosis	?
Due to Hypertension	—
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry Hyde M. D.
Address 1100 E Monument Date signed 1/16/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G24756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G24756

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Sinai Hospt

(c) Hospital or institution: Monument St

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 13

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 4127 Reisterstown Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Dubois, Hymon ALIAS William Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
about 48			hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER

12. Name ?

13. Birthplace ?

MOTHER

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Hospt Records.

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-45 (month) (day) (year)

(c) Cemetery or crematory Herring Run

Location Phil Rd & Bowleys Lane

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Baltimore St

JAN 16 1945 (b) Huntington Williams, M.D.

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-8 1945, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 1944, to 1-8 1945, and that I last saw h[illegible] alive on 1-8 1945.

Immediate cause of death	Duration
Cardiac Failure	
Due to Hypocardial Infarction	
Coronary Thrombosis	
Due to Arterio sclerotic C.V. Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jerome R. Dorsin M. D.

Address Sinai Hospital Date signed 1-9-45

G24757

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107 ✓ Registered No. G24757

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2125 E. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore C.t
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2125 E. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Behrnes (Behrens) ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25/44

8. AGE: Years | Months 3 | Days 19 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Benjamin Behrens
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Miller
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Mary Behrens
(b) Address 2125 E. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 17/45 (month) (day) (year)
(c) Cemetery or crematory St. Matthews Cem.
Location Balto. Md.

18 (a) Funeral director Philip Haurg Sons
(b) Address 2024 Orleans St.

19 (a) JAN 16 1945 (Date received by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14 1945, at 12.25 P M

21. I certify that I took charge of the remains described above, held an Inspection - Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury — at — M.

(b) Where did injury occur? —

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert L. Wolbarst M.D. Medical Examiner.

Date signed 1/17/45

4758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53

Registered No. G24758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Greenway Apartments
(b) Street address — Charles & 34th Sts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 78 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Charles & 34th Sts.
(If rural give location)
(e) Citizen of foreign country? --- (Yes or No)
If yes, name country ---

3 (a) FULL NAME Frances Helen Jenkins Hughes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: J. Albert Hughes

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1866

8. AGE: Years 78 | Months 11 | Days 23 | If less than one day -- hr. --- min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: None

11. Industry or business: ---

FATHER
12. Name: Felix Jenkins
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Nancy Jenkins
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Miss Nancy J. Offutt
(b) Address: Garrison, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/45 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville, Md.

18 (a) Funeral director: H. A. Mears and Son
(b) Address: 805 N. Calvert Street

19 (a) JAN 16 1945 (Date rec'd by registrar) Huntingtown Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 1945, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1943, to Jan 16 1945, and that I last saw her alive on Jan 15 1945.

Immediate cause of death: Chronic Nephritis — Duration: 3 years

Due to:

Due to:

Other Conditions: Epithelioma of face — 1½ yrs

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Frances W. Kluck M. D.
Address 715 Park Ave Date signed 1/16/45

VS 150

1318

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C24753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 6

Registered No. C24753

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1213 S. Light Street
(b) Street address 2524 [illegible]
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2524 Emerson St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES A. LLOYD

3 (b) If veteran, name war None

3 (c) Social Security Account No. 212-01-6354

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rosalie Lloyd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1903

8. AGE: Years 41 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Baltimore City

FATHER
12. Name Frisby Lloyd, Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Lynch
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Rosalie Lloyd
(b) Address 2524 Emerson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director Leo F. Schwab
(b) Address 2101 Frederick Avenue

19 (a) JAN 16 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15-1945 at 2.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13-1945 to 1-15-1945 and that I last saw him alive on 1-15-1945

Immediate cause of death
Rt. Lobar Pneumonia — Duration: 1 wk

Due to

Due to

Other Conditions Meningitis with B meningococcus septicemia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. Erlich M. D.
Address 1213 Light St Date signed 1-15-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

108

G24750 G24750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 H

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Gen. Hos.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 317 E. Cross Street Rooms
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Townsend

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10, 1891

8. AGE: Years	Months	Days	If less than one day
53	4	5	hr. min.

9. Birthplace Salisbury Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Isaac W. Towsend
13. Birthplace Wicomico County Md

MOTHER
14. Maiden Name Elizabeth Bradford
15. Birthplace Wicomico County, Md.

16 (a) Informant John D. Towsend
(b) Address 1226 N. Patterson Park Ave

17 (a) Burial (b) Date thereof 1-18-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parsons Cemetery
Location Salisbury, Md.

18 (a) Funeral director Geo. L. Schwartz & Son
(b) Address 2101 York Rd. Baltimore, Md.

19 (a) JAN 16 1945 (b) Huntington Indiana
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15- 1945; at 4 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating Gas.

Other Conditions Lobar Pneumonia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-14- at 4 M.
(b) Where did injury occur? 317 E. Cross St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Unlit, w burner gas stove.

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 1-15-45

G24751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24751 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square - D.S.H. 10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2425 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARY (Catherine) BRUMMER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
83	—	—	____ hr. ____ min.

9. Birthplace Canada
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Jacob Brummer
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Hoerber
15. Birthplace Germany

16 (a) Informant Records of Geo. L. Schwab
(b) Address 2101 Frederick Ave

17 (a) Burial (b) Date thereof 1-17-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md.

18 (a) Funeral director Geo. L. Schwab
(b) Address 2101 Frederick Ave

19 (a) 1 C 1945 (b) Hunting Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15 1945, at 11:55 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 1/16/45

VS 151

G24752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G24752
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: Kennedy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Fairburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Sullivan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Levi Sullivan
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Bosley
15. Birthplace Md.

16 (a) Informant Mrs. Charles Arnold
(b) Address Taneytown, Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Taneytown
Location Taneytown Md.

18 (a) Funeral director C. J. Fuss & Son
(b) Address Taneytown Md

19 (a) JAN 16 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 1945 at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12 1945 to 1-15 1945 and that I last saw her alive on 1-15 1945

Immediate cause of death Congestive heart failure + Pulmonary Edema — Duration
Due to Arteriosclerotic Heart disease
Due to
Other Conditions Emaciation - dehydration
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature D.W. Mentzer M. D.
Address Union Hosp. Date signed 1-15-45

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1572D

Registered No. G24763

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 Madison Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Philip Colman

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23 1944

8. AGE: Years	Months	Days	If less than one day
	9 10	21	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name John Briscoe
13. Birthplace Md.

MOTHER
14. Maiden Name Doris Johnson
15. Birthplace Md.

16 (a) Informant Doris Braxton
(b) Address 1548 Argyle Ave

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pressman
JAN 16 1945 Huntington Williams Hall
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14, 1945, at 6:15? M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Congenital Malformation of Brain

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed 1-16-45

VS 151

G24764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G24764
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Hospital Dept

(d) Length of stay in hospital or inst. (yrs., mos., or days) 30
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
Street No. 401 W. Patapsco
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Hosley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife N

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1890

8. AGE: Years	Months	Days	If less than one day
54	1	5	hr. min.

9. Birthplace Columbia So Carolina
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Emma Swaby
(b) Address 842 S. Eutaw St.

17 (a) Burial (b) Date thereof Jan 18, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Zion
Location Baltimore, Md

18 (a) Funeral director Joseph A. Lively
(b) Address 409 North Mount Street

19 (a) (Date rec'd by registrar) (Huntington Williams M.D.) Registrar

JAN 16 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15 1946, at M

21. I certify that I took charge of the remains described above, held an Inspection - Inquest and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Carter J. Johnson M.D.
Medical Examiner.
Date signed 1/15/46

G24765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G24765 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D-4
(b) Street address 762 W. Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 762 W. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelmina Lewis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 4 1914

8. AGE: Years	Months	Days	If less than one day
30	10	14	hr. min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Gale
13. Birthplace South Carolina

MOTHER
14. Maiden Name Sallie Alexander
15. Birthplace South Carolina

16 (a) Informant Charles F. Lewis
(b) Address 762 W. Franklin St.

17 (a) Burial (b) Date thereof 1/18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem. a a Co., Md
Location
18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.
19 (a) (b) Registrar

JAN 15 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15 1945, at 11:20 AM

21. I certify that I took charge of the remains described above, held an Inspection-Inquest and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said decedent came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tbc.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature ... M.D.
Medical Examiner
Date signed 1/20/45

X

G24786

JL - 91500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5718 Registered No. G24786

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 828 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Waters

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Ella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1876

8. AGE: Years	Months	Days	If less than one day
68	3	5	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Waters
13. Birthplace Md.

MOTHER
14. Maiden Name Rachel Freeland
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 1-18-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 15 1945 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14, 1945 at 10.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 9, 1945, to Jan. 14 1945, and that I last saw h im alive on Jan. 14 1945.

Immediate cause of death Uremia — Duration 2 wks.

Due to Adeno carcinoma of prostate with metastasis — 6 yrs.

Due and urinary obstruction

Other Conditions Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation 12-21-39

Major findings of operation: Adeno carcinoma of prostate

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Houck E. Belton M. D.
Address Balt. City Hosp. Date signed 1/15/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87D

G24757 Registered No.

Please write plainly, with INKING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave
(c) Hospital or institution:
German Aged Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Weber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1858

8. AGE: Years	Months	Days	If less than one day
86	6	9	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Weber
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Gove
15. Birthplace Germany

16 (a) Informant German Aged Home
(b) Address 22 S. Athol Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn Md

18 (a) Funeral director Henry H. Witzke
(b) Address 41 E. Lexington Ave
(c) Huntington Williams, M.D.

JAN 16 1945
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION 12 Noon.

20. DATE OF DEATH Jan. 14/45 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3/45 19 to Jan. 14/45.
and that I last saw her alive on Jan. 10/45.

Immediate cause of death	Duration
Multiple Sclerosis.	Unknown.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Weber Stevenson M. D.
Address 933 Hanover Date signed Jan 15/45.

VS 150

G24768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G24768 Registered No.

Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. PRINT WITH PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4801 Caleherne Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4801 Caleherne Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael E. Lynch

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1871

8. AGE: Years	Months	Days	If less than one day
73	2		hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Lynch
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Eaton
15. Birthplace Ireland

16 (a) Informant Mrs. J. J. Lynch
(b) Address 4801 Caleherne Rd

17 (a) Burial (b) Date thereof Jan. 16/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd
18 (a) Funeral director Harry H. Kirkpatrick
(b) Address 4101 Edmondson Ave.
19 (a) JAN 16 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar
(b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13 1945 at 4:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to Jan 13 1945, and that I last saw him alive on Jan 12 1945.

Immediate cause of death	Duration
Pulmonary edema	24 hrs
Due to Myocarditis	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. B. Van Schaick M. D.
Address 4818 Edmondson Ave Date signed Jan 15, 1945

G24759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G24759

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2901 Mosher St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2901 Mosher St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Howard H. Bloom

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mary C. Quinn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12, 1886

8. AGE: Years 58 | Months 5 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Proprietor Saloon

11. Industry or business

FATHER
12. Name Wm. Bloom
13. Birthplace Md

MOTHER
14. Maiden Name Louie —
15. Birthplace Md.

16 (a) Informant Mrs. Mary C. Bloom
(b) Address 2901 Mosher St

17 (a) Burial (b) Date thereof 1/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Catholic
Location 3900 Old Frederick Rd

18 (a) Funeral director Harry H. Withe
(b) Address 1012 E Monument St

19 (a) JAN 16 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944 to Jan 13 1945
and that I last saw h alive on Jan 13 1945

Immediate cause of death Hypostatic congestion of Lungs + Cirrhosis of Liver — Duration 1 week 3 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Samuels M. D.
Address 4309 Liberty Hgts Date signed Jan 15

VS 150

X

G24770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1576 Registered No. G24770

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo.

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md. (b) County ~~Baltimore~~
(c) City or town Govans, Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 6909 Dunman Way (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Leslie Carter Rhodes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1944

8. AGE: Years 0 | Months 1 | Days 0 | If less than one day ____ hr. ____ min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank K. Rhodes
13. Birthplace Penna

MOTHER
14. Maiden Name Elizabeth Carter
15. Birthplace Balto, Md.

16 (a) Informant Mrs Elm. Carter
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2401 Greenmount Ave

JAN 16 1945 (Date rec'd by registrar)

(b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15 1945 at 4:48 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1944 to 1-15 1945 and that I last saw her alive on 1-15 1945.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Partial atelectasis of left lung.	1 week
Due to Atresia of Esophagus.	Since birth
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 12-23-44 & 1-12-45

Major findings of operation: Congenital atresia of esophagus.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Fred Hopkins, Jr. M. D.
Address Union Memorial H. Date signed 1-15-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G24771

G24771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2040 Brookfield Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Philip Herman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12, 1883

8. AGE: Years: 62 | Months: 0 | Days: 3 | If less than one day: hr. min.

9. Birthplace Missouri (Town, county, and state)

10. Usual Occupation Tester & Assembler of

11. Industry or business Marine Pumps

FATHER
12. Name Solomon Herman,
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline Alkan
15. Birthplace France

16 (a) Informant Mrs. Ernest Herman
(b) Address 2040 Brookfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/45. (month) (day) (year)
(c) Cemetery ~~or crematory~~ Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director David Sonnheim & Son
(b) Address 902 Eutaw Place

JAN 16 1945 (Date rec'd by registrar)

(b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1945 at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 1944 to 1-15-1945, and that I last saw h.i.m alive on 1-15-1945.

Immediate cause of death	Duration
Respiratory failure	
Due to medullary compression	
Due to Acoustic Neuronoma	
Other Conditions Hypertensive Cardio Vascular Disease (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: Acoustic Neuronoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen C. Woodall M. D.

Address W. B. G. H. Date signed 1-15-45

X

A typed or printed, WITH UNFADING INK. Entry must be made in the office of the registrar. Physicians: please write the causes of death clearly and legibly. Certificate should be completed as completely as possible. Cause of death is especially important.

G24772 HEALTH DEPARTMENT—CITY OF BALTIMORE G24772

CERTIFICATE OF DEATH 83a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1233 Argyle Ave. Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Wm. Campbell

If U.S. Veteran specify WAR

(a) Residence: No. 1233 Argyle St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Susie Saunders

6. DATE OF BIRTH (month, day, year) June 4 1881

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	7	10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) (State or country) Md.

MOTHER FATHER

13. NAME Philip Carrington

14. BIRTHPLACE (city or town) (State or country) Md

15. MAIDEN NAME Sarah Talbot

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Susie Campbell

(Address) 1235 Argyle Ave.

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Auburn Cem Date 1-18-45

19. UNDERTAKER Mrs. Frances A. Hemsley

(Address) 578 W. Biddle St.

JAN 16 1945 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan 14 45

22. I HEREBY CERTIFY, that I attended deceased from ..... 19 ..... to ..... 19 .....

last saw h alive on Jan 13 45 Death is said to have occurred on the date stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:

Hemorrhage Brain.

Date of onset

Other contributory causes of importance:

Was an operation performed? Date of

For what disease or injury?

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
No (If so, specify)

(Signed) Frank E Hagner M.D.

(Address) 3027 Calvert

OCCUPATION is very important. See instructions on back of certificate.

G24773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1116

G24773 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address:
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 McCulloh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Nathan Day (NATHAN DAY)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nancey H. Day

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12, 1886

8. AGE: Years 58 | Months 5 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Porter

11. Industry or business

FATHER
12. Name: George Day
13. Birthplace: Va.

MOTHER
14. Maiden Name: Alice Lewis
15. Birthplace: Va.

16 (a) Informant: Mrs Nancey H. Day
(b) Address: 1916 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-45 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn Cem
Location: Baltimore, Md.

18 (a) Funeral director: Mrs Frances A. Hemsley
(b) Address: 578 W. Biddle St.

19 (a) JAN 16 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14- 1945; at 1 35 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Acute Pulmonary Edema

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Howard J. Mueller M.D.
Medical Examiner.
Date signed 1-15-45

VS 151

G24774 | BALTIMORE CITY HEALTH DEPARTMENT | G24774
CERTIFICATE OF DEATH
1340 | Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1156 Hull St. City (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Alphonsus Dougherty

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Roberts Dougherty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14 1896

8. AGE: Years	Months	Days	If less than one day
48	3	-	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Police Magistrate
11. Industry or business
FATHER 12. Name Michael Dougherty
13. Birthplace Ireland
MOTHER 14. Maiden Name Mary Hughes
15. Birthplace Ireland.
16 (a) Informant Mrs Mary Dougherty
(b) Address 1156 Hull St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location Baltimore Md.
18 (a) Funeral director Flynn & Fleming
(b) Address 1416 Light St.
(a) 1/16 1945 (b) (By registrar) Huntington Williams, M Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14 1945 at 4 45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1945 to 1/14 1945, and that I last saw him alive on 1/14 1945
Immediate cause of death Uremia — Duration 5 days.
Due to Pyelonephrosis — ?
Due to Nephrolithiasis — ?
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury
23. Signature E. Sigmund Kaye M. D.
Address Bon Secours Hosp Date signed 1/16/45

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G24775

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 338 E. Lorraine ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 338 Lorraine ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Guy Everett Tyler

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Olga Tyler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1891

8. AGE: Years	Months	Days	If less than one day
53	8	11	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Baltimore News

FATHER
12. Name John Wesley Tyler
13. Birthplace Va

MOTHER
14. Maiden Name Susan Eastman
15. Birthplace Va

16 (a) Informant Rev Thos. Bryan
(b) Address 2457 Md Ave.

17 (a) Removal (b) Date thereof Jan 17, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Elmwood
Location Birmingham, Ala.

18 (a) Funeral director D. L. Covington
Address 21 W 25 St.

19 (a) JAN 16 1945 (Date rec'd by registrar) (b) Huntington Williams III Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1945, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 17 1944, to Jan 15 1945, and that I last saw him alive on Jan 14, 1945

Immediate cause of death	Duration
Coronary thrombosis	
Due to intestinal influenza	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm B Deale M. D.
Address 2435 Md Ave. Date signed 1/15/45

X

G24776 G24776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 84D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Rd.
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-3-1
(e) Length of stay in Baltimore (yrs., mos., or days) 1-3-1

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Virginia (b) County
(c) City or town Martinsburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. 429 West Martin St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Unger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1895

8. AGE: Years 49 | Months 4 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Green
13. Birthplace West Virginia

MOTHER
14. Maiden Name Mary E. Wright
15. Birthplace Martinsburg, W. Va.

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Road

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-16-45 (month) (day) (year)
(c) Cemetery or crematory Martinsburg W. Va.
Location

18 (a) Funeral director L. C. Higinbothom
(b) Address Ellicott City, Md.

19 (a) (Date rec'd by registrar) (b) Huntington W. Va. Registrar

JAN 16 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 1945, at 12:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1943, to Jan. 16 1945, and that I last saw her alive on Jan. 16 1945.

Immediate cause of death: Malnutrition
Due to: Circulatory collapse
Due to:
Other Conditions: Involutional psychosis
(Include pregnancy within 3 months of death)

Duration
1 mo.
15 mo.

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. F. Alexander M. D.
Address 33 W. Eutaw St. Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 138

Registered No. G24777

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hosp. Balto. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 18 da
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs. (47)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 201 E. Univ. Parkway.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country.....

3 (a) FULL NAME Helen W. Strohmeyer

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 215-10-5735

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: George Oscar Strohmeyer
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1894

8. AGE: Years 51 | Months 0 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Stenographer
11. Industry or business Poor, Bartlett & Kennedy

FATHER
12. Name Thomas E Davis.
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Hass.
15. Birthplace Maryland (Balto)

16 (a) Informant Mrs. Maril Kraus
(b) Address 201 E. Univ. Parkway.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (c) (By registrar) Huntington Williams, M.D. Registrar

1-16-1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14 1945, at 10 39 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 26 1944, to Jan 14 1945, that I last saw her alive on Jan 14 1945.

	Duration
Immediate cause of death: Cardiac and Pulmonary failure	Minutes
Due to: Severe Anemia & Leukemia	1 mo or more
Due to: Persistent Hemorrhage from G. I. Tract.	1 mo or more
Other Conditions: Pulm. Tuberculosis	?

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature John F. Willperger M. D.
Address Mercy Hosp. Date signed 1/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

24778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G24778 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1629 Ceddox St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Ceddox St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anthony Bartoch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	M.

6 (b) Name of husband or wife Tillie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
About 54			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Grain Operator
11. Industry or business Davison Chemical Co

FATHER
12. Name —
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland.

16 (a) Informant Tillie Bartoch
(b) Address 1629 Ceddox St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17-45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern ave

19 (a) JAN 16 1945 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 14 1945 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1945, to Jan 14 1945, and that I last saw living alive on Jan 14 1945.

Immediate cause of death Carcinoma of Intestine with metastasis to
Due to Lungs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury Carl Lukens

23. Signature
Address 920 Aisquith Ave Date signed 1/15/45 M. D.

VS 180

Please write plainly with pen and black ink. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Item 19 (a) is especially important.

G24779 G24779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V124B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2212 Booth St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Heyeard

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Booth St
(If rural give location)
(e) Citizen of foreign country? ... (Yes or No)
If yes, name country ...

3 (a) FULL NAME John Dillinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
MALE	WHITE	MARRIED

6 (b) Name of husband or wife Caroline Dillinger
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) May 1st 1884

8. AGE: Years	Months	Days	If less than one day
60	8 7	14	... hr. ... min.

9. Birthplace Hungary (town, county, and state)
10. Usual Occupation Shoemaker
11. Industry or business Owner

FATHER
12. Name Michael Dillinger
13. Birthplace Hungary

MOTHER
14. Maiden Name Unknown
15. Birthplace Hungary

16 (a) Informant Caroline Dillinger
(b) Address 2214 Booth St

17 (a) Burial (b) Date thereof 1/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md

18 (a) Funeral director J. C. Wilhelm Son
(b) Address 300 Eutaw Place

19 (a) JAN 16 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14 1945, at 4 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944, to 1/14 1945, and that I last saw him alive on 1/14 1945.

Immediate cause of death Cirrhosis of Liver — Duration 2 yrs

Due to ...

Due to ...

Other Conditions Arteriosclerosis C.V. Disease

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Chester J. Lubinski M. D.
Address 5217 Garrison Blvd Signed 1/16/45

X

Please write plainly, with unfading ink. Employ a competent informant who can correctly supply the facts required. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

G24780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G24780

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1206 W. North Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1206 W. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tillye Sachs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 Months 66 Days If less than one day hr. min.

9. Birthplace New York City (Town, county, and state)

10. Usual Occupation

11. Industry or business House work

FATHER
12. Name Abraham Solomon
13. Birthplace London

MOTHER
14. Maiden Name Anne ?
15. Birthplace London

16 (a) Informant Sylvan Sachs
(b) Address 1206 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 17, 1940 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Rd
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date received by Registrar) JAN 16 1940 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1940, at 2 P M

21. I certify that I took charge of the remains described above, held an Inspection-Enquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Clayton S. Lubansky M.D. Medical Examiner.
Date signed Jan 16 1940

Write the causes of death clearly and legibly. Physicians: please write plainly. Do not use abbreviations.

C21781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

Registered No. C21781

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Mt Hope Retreat (If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. John Howard - O.S.A.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace (Town, county, and State)
10. Usual Occupation Clergyman & Priest
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Hospital Record
(b) Address Caton & Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/45 (month) (day) (year)
(c) Cemetery or crematory
Location Lawrence Mass.

18 (a) Funeral director Martin Fahy & Sons
(b) Address 1827 W. North Ave.

19 (a) (Date received by Registrar) (b) Hunting for Williams M.D. Registrar

JAN 17 1945
VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 1945, at 2:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-8 1945 to 1-16 1945, and that I last saw him alive on 1-16 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic hypertensive C-V disease	
Due to	
Other Conditions Fractured right femur (neck) (Include pregnancy within 3 months of death)	

Date of operation 1-15-45
Major findings of operation: Fracture neck of right femur
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 1-7 at 2:30 PM
(c) Where did injury occur? Baltimore Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Mt Hope Retreat (Specify type of place) Was he at work? No
(e) Means of injury Fall to the floor
23. Signature: Howard OSA
Address St Agnes Hosp Date signed 1-16-45 M. D.

Dr C. J. Zubrinski
approved Howard J. Masonis M.D.

Plock

G24782 BALTIMORE CITY HEALTH DEPARTMENT G24782

CERTIFICATE OF DEATH 124B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1542 Carswell St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad Plock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband~~ or wife Marie Plock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13th 1882

8. AGE: Years	Months	Days	If less than one day
63	0	3	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Book Keeper
11. Industry or business Sale & Co

FATHER
12. Name Henry Plock
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Strouse
15. Birthplace Md

16 (a) Informant W. Gordon Plock
(b) Address 3002 Chesley Ave

17 (a) Burial (b) Date thereof 1/19/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul st.

19 (a) Huntington Williams, M.D.
(Signature of registrar) Registrar

JAN 17 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-16 1945 at 4 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1945 to 1-16 1945 and that I last saw him alive on 1-16 1945

Immediate cause of death Bleeding from Rupture esophageal varices — Duration 1 day

Due to cirrhosis of liver — Duration yrs.

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers M.D.
Address Franklin Square Hosp Date signed 1-16-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24783 | BALTIMORE CITY HEALTH DEPARTMENT | G24783

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2124 W. Saratoga
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2124 W. Saratoga
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Paul

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Christie Paul
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1880

8. AGE: Years	Months	Days	If less than one day
64 65	11 0	29 0	hr. min.

9. Birthplace
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Cosmo Angelucci
13. Birthplace Italy

MOTHER
14. Maiden Name Providenza Merlinda
15. Birthplace Italy

16 (a) Informant Mrs. Mary Mc Laughlin
(b) Address 2125 W. Mulberry St.

17 (a) Burial (b) Date thereof 1-17-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

JAN 17 1945 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14 1945, at 12 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocarditis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McAbby
Medical Examiner.
Date signed 1/15/45

G24784 ✓ G24784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1648

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address City Morgue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 Thames St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If so, name country Reedy

3 (a) FULL NAME Pearl (Kaminski) SIBICKI Reedy

3 (b) If veteran, name war YES (c) Social Security Account No. UNKNOWN

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband ~~ex-wife~~ JOHN SIBICKI
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years	Months	Days	If less than one day
31			hr. min.

9. Birthplace Harrisonburg Va
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Reedy
13. Birthplace ?

MOTHER
14. Maiden Name Elizabeth Emanueller
15. Birthplace

16 (a) Informant FANNIE JORDAN
(b) Address 1738 THAMES ST

17 (a) Burial (b) Date thereof 1-17-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location Baltimore Md

18 (a) Funeral director Geasey & Weber
(b) Address 705 S. Chas st

19 1-17-1945 Huntington Williams M.D.
(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14th 1945, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Jan 13 1945 M.
(b) Where did injury occur? Harbor foot of Ann St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Found drowned

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Jan 15th 1945

VS 151

G24785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G24785

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3916 Bonner Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3916 Bonner Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA LOTT

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife CHARLES
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name MORRIS
13. Birthplace RUSSIA

MOTHER
14. Maiden Name LEAH
15. Birthplace RUSSIA

16 (a) Informant HARRY LOTT
(b) Address 2222 BROOKFIELD AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-17-45 (month) (day) (year)
(c) Cemetery or crematory SOUTHERN AVE
Location SOUTHERN AVE

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. Balto. ST.

19 JAN 17 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-16-45 19 , at 6.30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 1944, to 1/15 1945 and that I last saw h[illegible] alive on 1/15 1945.

Immediate cause of death	Duration
Acute Pulmonary Edema	
Acute Cardiac failure	
Due to	
Due to Chronic Myocarditis	
Other Conditions Chronic Sclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. H. Stoltenstein M.D.
Address 703 Augusta St. Date signed 1/16/45

Please write plainly, with ordinary pen. Every item should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G24786 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 216 Mason Court
(c) Hospital or institution:
3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 216 Mason Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernie M. George

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry E.

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1899

8. AGE: Years 45 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Warms Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name James Abott
13. Birthplace Va.

MOTHER
14. Maiden Name Gertrude Webster
15. Birthplace Va

16 (a) Informant Henry E. George
(b) Address 216 Mason Court

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1/17/45 (month) (day) (year)

(c) Cemetery or crematory White Stone Baptist Church, Va
Location White Stone Va.

18 (a) Funeral director W. W. E. Bryant & Sons.

(b) Address Lombard & Fremont Sts.

19 (a) Filed 1945 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1945 at 4:50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6-45 to 1-16-45
and that I last saw h.. alive on 1-15 1945

Immediate cause of death Hypertensive Cardio-Vascular Renal Disease — Duration 1 Yr 1½ Yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edw Stacy F. Barrow

Address 527 York Rd Date signed 1/18/45

VS 150

Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

Registered No. G24787

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5212 Denmore Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME George E. Roberts Jr

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	-

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23 1939

8. AGE: Years	Months	Days	If less than one day
5	2	22	.....hr. .....min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name George E. Roberts Sr
13. Birthplace Va

MOTHER
14. Maiden Name Ruth James
15. Birthplace Baltimore

16 (a) Informant Marie Wade
(b) Address 3311 Paton ave

17 (a) Burial (b) Date thereof 1-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. & O. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) JAN 17 1945 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 1945, at 6:05 P. M.

21. I certify that I took charge of the remains described above, held an Inquestion thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to 2nd degree burns

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-15-45 at 11:42 A. M. 27/18
(b) Where did injury occur? 5212 Denmore Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury oil stove exploded

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Jan 16 1945 19

VS 151

G24788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

Registered No. G24788

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5212 Belmore ave.
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Richard Roberts

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	-

6 (b) Name of husband or wife -
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 2/18/1941

8. AGE: Years	Months	Days	If less than one day
3 4	10	27	____ hr. ____ min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name George E Roberts
13. Birthplace Va

MOTHER
14. Maiden Name Ruth James
15. Birthplace Baltimore

16 (a) Informant Marie Wade
(b) Address 3311 Paton AVE

17 (a) Burial (b) Date thereof 1-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

19 (Date received by Registrar) JAN 17 1945 (Signature of Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15th 1945, at 9:50 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to 3rd degree burns

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

over

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 27/18

(a) Date of injury 1-15-45 at 11:42 A M.
(b) Where did injury occur? 5212 Belmore Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury oil stove exploded.

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed Jan 16 1945

VS 151

G24789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

Registered No. G24789

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5212 Denmore Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vivian Roberts

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-6-1942

8. AGE: Years	Months	Days	If less than one day
2	10	9	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name George E Roberts
13. Birthplace Va

MOTHER
14. Maiden Name Ruth James
15. Birthplace Baltimore

16 (a) Informant Marie Wade
(b) Address 3311 Eaton AVE.

17 (a) Burial (b) Date thereof 1-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

19 (a) JAN 17 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15th 1945, at 5:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to
2nd degree burns

Due to

Other Conditions over

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 27/18

(a) Date of injury 1-15-45 at 11:42 A.M.
(b) Where did injury occur? 5212 Denmore ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Oil stove exploded.

23. Signature Robert A. Graham M.D.
Medical Examiner.
Date signed Jan 16 1945

VS 151

24790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G24790
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1420 Orlean St
(c) Hospital or institution: 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 Orlean St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida L. Freeman

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Married

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) 1/28/1893

8. AGE: Years	Months	Days	If less than one day
51 5 3	11	17	hr. min.

9. Birthplace Richmond Co. Va
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Arthur Dunaway
13. Birthplace Va

MOTHER 14. Maiden Name Frances Day
15. Birthplace Va

16 (a) Informant Rose Dunaway
(b) Address 917 N. Dallas St

17 (a) Shipped (b) Date thereof 1 18 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Dourmunds
Location Virginia

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

JAN 17 1945 (b) Huntington Williams, M.F.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 14 1945 at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to Jan 14 1945 and that I last saw h alive on 19

Immediate cause of death Duration

Due to Acute Bronchial Pneumonia 4 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation no
Major findings of operation: —

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. L. [redacted]
Address 121 [redacted] Date signed Jan 15 1945 M. D.

G24791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

G24791
Registered No.

Correct age if necessary. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 232 Cape May Rd.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Bernard J. Schlebeck Shiebeck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Married

6 (b) Name of husband or wife Margaret Mary Gurske
6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) Nov. 27 - 1920

8. AGE: Years	Months	Days	If less than one day
24	1	19	hr. ..... min.

9. Birthplace Balto. Co. (Essex)
(Town, county, and state)
10. Usual Occupation Catcher
11. Industry or business Eastern Rolling Mills

FATHER
12. Name Joseph F. Shiebeck
13. Birthplace Austria

MOTHER
14. Maiden Name Frances Bentley
15. Birthplace Balto.

16 (a) Informant Mrs. Margaret Shiebeck
(b) Address Bengies Rd. Middle River

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 18 - 45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd.

18 (a) Funeral director Thos. G. Connelly
(b) Address 418 Eastern Ave. Essex

19 (a) Date rec'd by Registrar Jan 17 1945 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1945, at 2:15 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab Wound
of Chest
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 15 1945 (10 A M.)
(b) Where did injury occur Lambert's Tavern, Middle River
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Stabbing

23. Signature Robert A. Gratton M.D.
Medical Examiner.
Date signed Jan 15 1945

VS 151

S.O.R. BALTIMORE CITY HEALTH DEPARTMENT X ✓ G21792

Medical Examiner Case CERTIFICATE OF DEATH 12 for Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 343 Savannah Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harold J. Long.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male. | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Helen Long nee Phelps | 6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) April 20 - 1911

8. AGE: Years 33 | Months 9 | Days 25 | If less than one day hr. min.

9. Birthplace Atlanta, Ga. (Town, county, and state)

10. Usual Occupation Machenist

11. Industry or business Castings Iron + Steel Co.

FATHER — 12. Name Irving Long
13. Birthplace Kentucky

MOTHER — 14. Maiden name Belle Mills
15. Birthplace Atlanta, Ga.

16 (a) Informant Bonds.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 17-45 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Taylor Ave. B. C.

18 (a) Funeral director John J. Connelly
(b) Address 419 Eastern Ave Balto 21

19 (a) JAN 17 1945 (Date rec'd by registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Jan. 14 1945, at 12.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13 1945 to 1-13 1945 and that I last saw him alive on 1-13 1945

Immediate cause of death: acute pancreatitis — Duration: 36 hours
Due to [redacted]
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 1-13-45
Major findings of operation: pancreatitis [redacted]
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George Bunch M.D.
Address J.H.H. Date signed 1-14-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

4793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832

G24793 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4512 Mainfield Ave
(c) Hospital or institution: DOA.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 5129 Hartford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wm. J. Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1874

8. AGE: Years 70 | Months 3 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Utility Man

11. Industry or business Wagners

FATHER 12. Name John Thompson

13. Birthplace Germany

MOTHER 14. Maiden Name Augusta Kellgen

15. Birthplace Germany

16 (a) Informant M. C. Hagedorn HAGedorn

(b) Address 401 S Clinton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/45 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Groudon Sec L. Heimann & Co

18 (a) Funeral director

(b) Address 32 S. Broadway

19 (a) JAN 17 1945 (Date rec'd by registrar) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/17 1945, at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy - Inquest thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury — at — M.

(b) Where did injury occur? —

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Chester Ludwick M.D. Medical Examiner.

Date signed 7/19/45

VS 151

C24794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. C24794

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington St.
(c) Hospital or institution: Aged Women's & Aged Mens Homes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME miss Ida F. Jones

3 (b) If veteran, name war .....
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 11-1864

8. AGE: Years	Months	Days	If less than one day
80	4	4	..... hr. ..... min.

9. Birthplace St. Michaels, Md
(Town, county, and state)
10. Usual Occupation Retired Attendant
11. Industry or business

FATHER
12. Name Edward Jones
13. Birthplace St. Michaels Md

MOTHER
14. Maiden Name Elizabeth Marshall
15. Birthplace St. Michaels Md

16 (a) Informant Aged Womens & Aged Mens Homes
(b) Address 1400 W Lexington St.

17 (a) Burial (b) Date thereof Jan. 18 1945
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Saint Thomas
Location Reisterstown Road, Owings Mills
18 (a) Funeral director Wm Berryman & Sons
(b) Address Reisterstown, Md.
19 (a) Huntington Williams, M.D.
Registrar
Date received by registrar JAN 17 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15 1945 at 9.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/19/1930 to 1/15/1945. and that I last saw her alive on 1/14 1945

Immediate cause of death Apoplexy — Duration 1 wk.
Due to .....
Due to .....
Other Conditions Hypertensive cardio-vascular disease.
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work?
(Specify type of place)
(e) Means of injury .....

23. Signature Edward B Jarrell M. D.
Address 11 E. Chase St., City Date signed 1/17/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

466 Registered No. G24795

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 11/21/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 11/21/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1931 S. 21st Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN CLARKSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	091-16-4779

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife XX Anna May Wright
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 3/17/1906

8. AGE: Years	Months	Days	If less than one day
38	9	30 2/9	hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation Drag Tender-U.S.Dradge
11. Industry or business " Raritan

FATHER
12. Name Henry Clarkson
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Elizabeth Doran
15. Birthplace Philadelphia, Pa.

16 (a) Informant Records, U.S.Marine Hospt.
(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof Jan 20 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Philadelphia, Pa.

18 (a) Funeral director John L. Deneys & Inc
(b) Address 715 Light St.

19 (a) JAN 17 1945 Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH January 15, 1945, at 7:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21, 1944, to Jan. 16, 1945, and that I last saw him alive on Jan. 16, 1945.

Immediate cause of death	Duration
Carcinoma of the head of the Pancreas with metastasis in the Liver and ~~XXXX~~ abdominal lymph nodes.	Had first indication 2 weeks prior to admission
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Exploratory lap. 12/20/44

Major findings of operation: Carcinoma of the head of the pancreas with metastasis & secondary pancreatitis

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Patterson
Surgeon, USPHS,
Address Baltimore, Md. Executive Officer Date signed 1/16/45

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 180

USEC-56984

G24796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24796 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Church Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 E. Baltimore St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mr. David Caplan

3 (b) If veteran, name war —

3 (c) Social Security Account No. 247-03-9527A

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Mrs Ann Caplan

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) ?? 1877

8. AGE: Years 68 66 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business none

FATHER
12. Name Benny Caplan
13. Birthplace Russia

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr Louis Caplan
(b) Address 3226 W. Garrison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-45 (month) (day) (year)
(c) Cemetery or crematory Pikesdale
Location —

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St

19 (a) 171945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-16 1945, at 5:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16 1945 to 1-16 1945 and that I last saw h[illegible] alive on 1-16 1945.

Immediate cause of death	Duration
Acute cardiac failure	48 hrs
Due to Arteriosclerotic Heart Disease	3-4 yrs
Due to	
Other Conditions ? Auricular fibrillation	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marvin W. Davis M. D.
Address Church Home Date signed 1-16-45

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

Registered No. C24797

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1542 Bruce St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1542 Bruce St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Carter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife William Carter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1862

8. AGE: Years	Months	Days	If less than one day
83 82			hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Angella Horsey
(b) Address 1542 Bruce St

17 (a) Burial (b) Date thereof 1/18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Pressstman St
JAN 17 1945 Huntington Williams M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1945, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945, to Jan 15 1945, and that I last saw her alive on Jan 8 1945.

	Duration
Immediate cause of death Fracture of right hip	2 mo's
Due to Hypostatic Pneumonia	7 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 15/2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Nov. 1944 at A.M.
(c) Where did injury occur? Balto Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Slipped & Fell in kitchen

23. Signature E. William Frey M.D.
Address 1928 Pa Ave Date signed 1/17/45

VS 150

affidavit by Howard J. Heinecke, M.D. 1/17/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. C24793

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1406 Rugg Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1406 Rugg Ave.
(If rural give location)
(e) Citizen of foreign country? No, (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Stewart

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Henry Stewart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1884

8. AGE: Years	Months	Days	If less than one day
60	8		hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Agnes Stewart
(b) Address 1406 Rugg Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 303 Presstman St
JAN 17 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1945, at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1944, to Jan 15 1945, and that I last saw her alive on Jan 15 1945.

Immediate cause of death	Duration
Cardio Vascular Disease	6 mos
Due to Broken Compensation	2 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emelleen Frey M. D.
Address 1928 Pa Ave Date signed 1/17/45

VS 150

Please write plainly, with pen and ink. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G24799

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 322 Diamond St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto (b) County
(c) City or town Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 322 Diamond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Mc Coy

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	M

6 (b) Name of husband or wife George H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/10/1894

8. AGE: Years	Months	Days	If less than one day
50	3	4	hr. min.

9. Birthplace Va.
(Town, county and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Jim Thompson
13. Birthplace Va.

MOTHER
14. Maiden Name Laura Thompson
15. Birthplace Va.

16 (a) Informant George McCoy
(b) Address 322 Diamond St

17 (a) Burial (b) Date thereof 1/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Richmond
Location Richmond Co. Va.

18 (a) Funeral director Geo. H. Kelso
(b) Address 1303 Preastman St.

JAN 17 1945 (b)
(Date rec'd by Registrar) Registrar for Williams Dist.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14 1945 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1945 to 1/14 1945 and that I last saw h[illegible] alive on 1-14 1945

Immediate cause of death Cardio-Renal

Duration
4 Days
1/14/45

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 1/17/45

Funeral directors, physicians, and others should be extremely careful that information entered on this certificate is correct and complete. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G24800

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G24800

Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2216 Calvert St
(c) Hospital or institution: D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2216 N. Calvert St (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Reginald Budd Moffett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single

6 (b) Name of husband or wife ---------

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1886

8. AGE: Years	Months	Days	If less than one day
59.	--	1 --	-- hr. -- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Grocer

FATHER
12. Name William H. Moffett
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Rose Budd
15. Birthplace New Jersey

16 (a) Informant W. Edwin Moffett
(b) Address 2216 N. Calvert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director H. W. Meads and Son
(b) Address 805 N. Calvert Street

19 JAN 17 1945 (Date received by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/16 1945, at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and from the evidence obtained (Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Chester L. Tubin M.D. Medical Examiner.
Date signed 1/16/45

G24801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. G24801

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3011 Clifton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3011 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** HARRY J. WINDER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Laetitia Winder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1882

8. AGE: Years	Months	Days	If less than one day
62	8	7	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Truck Repairs
11. Industry or business Self

FATHER
12. Name Richard J. Winder
13. Birthplace Matthews Co., Va.

MOTHER
14. Maiden Name Lucy Crafton
15. Birthplace Middlesex Co., Va.

16 (a) Informant Mrs. Laetitia Winder
(b) Address 3011 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 / 18 / 45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) JAN 17 1945 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Jan. 15, 1945, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1944 to Jan 15. 1945.
and that I last saw be alive on Jan 15 1945.

Immediate cause of death	Duration
Angina Pectoris.	4 hrs.
Due to Chronic Myocarditis	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert J. Blake M. D.
Address Med. Arts Bldg. Date signed

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

C-21803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C21803

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Denison St.
(c) Hospital or institution:
Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2315 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY A. SCHANBERGER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry P. Schanberger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1874

8. AGE: Years 70 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Cornelius Noonan
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant: Mr. John Schanberger
(b) Address: 1123 Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/45 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore, Md.

JAN 17 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 14, 1945, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1944 to Jan 14 1945 and that I last saw h.er alive on Jan 14 1945.

Immediate cause of death: Cardiac Asthenia — Duration: 4 days, 2 months

Due to: Coronary Thrombosis — Duration: 2 yrs.

Due to:

Other Conditions: Hypertension — Duration: 2 yrs.

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Martin W. Stout M. D.
Address: 2263 Fulton Ave. Date signed 1-16

VS 150

C24803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

C24803 Registered No.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every blank must be filled. WRITE PLAINLY, WITH UNFADING INK. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1526 Retreat St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

135

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 Retreat St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HORACE J. NELKER

3 (b) If veteran, name war --

3 (c) Social Security Account No. 212-07-8537

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/24/1878

8. AGE: Years	Months	Days	If less than one day
66	1	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Salesman
11. Industry or business Frey & Son

FATHER
12. Name A. Henry Nelker
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa H. Greasley
15. Birthplace Balto., Md.

16 (a) Informant Miss Lucy H. Nelker
(b) Address 1526 Retreat St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (c) JAN 17 1945 (Date rec'd by registrar) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16, 1945, at 4:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7th 1944 to Jan. 16 1945, and that I last saw h. alive on Jan. 14 1945.

Immediate cause of death Coronary occlusion — Duration, 10 mon.

Due to Advanced arterio-sclerosis + hypertension ? ? ?

Due to

Other Conditions Hypertension ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If ~~death was due to external causes~~, fill in the following:
(a) Accident, suicide, or homicide ?
(b) Date of occurrence at M
(c) Where ~~did injury occur~~? (City or town) (County) (State)
(d) Did injury ~~occur about home, on~~ farm, industrial place, in public place? (~~Specify type of place~~) While at work?
(e) Means of injury

23. Signature Walter S. Nelker M. D.
Address 2220 Harrison Date signed 1/17/45

VS 150

G24804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95D

G21804 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 Rutland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Rutland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: CLARA JANE KEIL

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Frank Keil

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1867

8. AGE: Years 77 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace: Frederick, Maryland (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: Henry Bentz
13. Birthplace: Frederick, Md

MOTHER
14. Maiden Name: Catherine DeGrange
15. Birthplace: Frederick, Md

16 (a) Informant: Mrs. George Young
(b) Address: 822,5th St.N.E. Wash. D. C.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 1-17-45 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave. & Broadway

19 (a) 1/17/45 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 14 1945, at 6 P. M. A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1944 to Jan 14 1945 and that I last saw her alive on Jan 14 1945

Immediate cause of death: Acute Bronchitis
Cardiac Dilatation — Duration: 10 Days / 18 Days

Due to:

Due to:

Other Conditions: Cardiac Hypertension / Diabetes — Duration: 7 Years

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Albert Eisenberg

Address: 2025 E North Ave Date signed 1/15/45

VS 150

24805 1-Transcript LAUBER BALTIMORE CITY HEALTH DEPARTMENT G24805

CERTIFICATE OF DEATH V 52a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison - Linden
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2306 Monticello Rd.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Adam Ernest Lauber

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Nettie Marie Lauber
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1892

8. AGE: Years	Months	Days	If less than one day
52	1	17 16	— hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Insurance - Dentist
11. Industry or business "

FATHER
12. Name Henry Lauber
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Lauber
15. Birthplace Germany

16 (a) Informant wife
(b) Address 2306 Monticello Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Loving Byers
(b) Address 5005 Park Heights Ave

19 (a) JAN 17 1945 (Date rec'd by registrar) Huntingtor Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 1945, at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1945, to Jan. 16 1945, and that I last saw him alive on Jan. 16 1945.

Immediate cause of death Cardio - Respiratory failure — Duration

Due to Lung metastases

Due to adeno-carcinoma of Left kidney.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct. 6, 1944

Major findings of operation: Adenocarcinoma of Left kidney.

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Meat M. D.
Address Md. Gen. Hospital Date signed Jan. 16, 1945

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to give correct age in years, months, and days. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24806

1 Transcript

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G24806

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5206 Wilton Hts ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5206 Wilton Hts ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick G. Minton

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-9005

4. Sex male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife May Minton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March-10-1888

8. AGE: Years 57 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Ticket agent

11. Industry or business Md. Jockey Club

FATHER
12. Name George Minton
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Virginia Loring
15. Birthplace Baltimore Md

16 (a) Informant May Minton
(b) Address 5206 Wilton Hts

17 (a) Burial (b) Date thereof 1-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Heights Ave

19 (a) JAN 17 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15/1945, at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10/1945 to 1/15/1945, and that I last saw him alive on 1/14/1945.

Immediate cause of death Uraemia — Duration

Due to Hypertension — Duration

Due to Nephritis — Duration

Other Conditions Myocarditis — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Frankel M. D.

Address 1 W Lee St Date signed 1/15/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

eighty eight

G24807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1004 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St
(c) Hospital or institution:
Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4801 Cordelia Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sharon Randecker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/21/44

8. AGE: Years	Months	Days	If less than one day
	4	25	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name William S. Randecker
13. Birthplace Allport Pa

MOTHER
14. Maiden Name Almedia James
15. Birthplace Baltimore Md

16 (a) Informant William S. Randecker
(b) Address 4901 Cordelia ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Loving Byers
(b) Address 5005 Park Heights ave

19 (a) 1-17-1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15 1945; at 7.21 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2 1945, to 1-15 1945; and that I last saw her alive on 1-15 1945.

Immediate cause of death Internal Hemorrhage — Duration

Due to Ruptured uterus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams M. D.
Address Univ. Hosp. Date signed 1-15-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2480 Transcript

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

G24808 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Gen Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 Spalding ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Soffell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Linden, Va
(Town, county, and state)
10. Usual Occupation Sheet Metal Worker
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Sylvia Soffell
13. Birthplace Linden, Va

MOTHER
14. Maiden Name Virginia Casey
15. Birthplace Va.

16 (a) Informant Lori Lee Soffell
(b) Address 3106 Spalding Ave

17 (a) Burial (b) Date thereof 1/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Lorin Byers
(b) Address 5005 Old Harford Ave

19 JAN 17 1945 Huntington Williams M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15 45 at 4:19 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 45 to 1-15 1945 and that I last saw h/M/alive on 1-15-45

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Hypertension

Due to:

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. D. Yaxaway M. D.
Address S. Balto Gen Hosp

24809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

Registered No. G24809

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 W. Hamburg St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Frank Kowalski

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife V. Kowalski
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Not know ?

8. AGE: Years	Months	Days	If less than one day
About 60?			....hr. ....min.

9. Birthplace Russian
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Railroad - B&O

FATHER
12. Name Not know
13. Birthplace Russian

MOTHER
14. Maiden Name Not know
15. Birthplace Russian

16 (a) Informant Mrs. F. Miller
(b) Address 118 W. Hamburg St

17 (a) Burial (b) Date thereof Jan. 17-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Stony Run, Md to A.A. County

18 (a) Funeral director John A. Gnebliancka Jr
(b) Address 423 S. Paca St

19 (a) JAN 17 1945 (b) Huntington Willis REGISTRAR
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1945, at 12:5a M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed thigh, right, Compound comminuted fracture, left tibia & fibula

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 22/2

(a) Date of injury January 12, 1945 M.
(b) Where did injury occur? Exchange, Cameron St.
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury Struck by train

23. Signature Robert Lee Grafton M.D.
Medical Examiner.
Date signed Jan 15 1945

G24810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G24810

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4701 N. Charles Street
(c) ~~Hospital~~ or institution:
Notre Dame of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 49 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore Co.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4701 N. Charles Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary Nila (Gertrude Miller)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/18/1862

8. AGE: Years	Months	Days	If less than one day
82	8	28	hr. min.

9. Birthplace Syracuse, New York
(Town, county, and state)
10. Usual Occupation Domestic work
11. Industry or business

FATHER
12. Name Caspar Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Watley
15. Birthplace Germany

16 (a) Informant Sister Mary Frances
(b) Address Notre Dame of Maryland

17 (a) Burial (b) Date thereof 1/18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Notre Dame of Md.

18 (a) Funeral director Geo. M. Kenck Son
(b) Address 611 N Wolfe St

JAN 17 1945
(Date rec'd by Registrar) (b) Huntington Millington, Baltimore, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1945, at 10:1 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 20 1944 to Jan 16 1945 and that I last saw h~~er~~ alive on Jan 16 1945

Immediate cause of death Coronary Thrombosis — Duration 1/2 hr

Due to Advanced Myocardiosis

Due to Advanced Arterio Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Frances L. Bagli, M. D.
Address 6077 Hayfield Rd Date signed 1/16/46

correct age is especially important. Physicians: please write the

G24811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13-B

G24811 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 329 WEST 30th STREET.
(c) Hospital or institution:
NO 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) NO
(e) Length of stay in Baltimore (yrs., mos., or days) 8.MONTHS

2. USUAL RESIDENCE OF DECEASED:
(a) State VIRGINAI (b) County
(c) City or town HOPEWELL. (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 NORTH 9th STREET (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE WALTER FIELDS.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14- 1900

8. AGE: Years 44 45 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name John W. Fields

13. Birthplace Va.

MOTHER 14. Maiden Name Mary P Samuel

15. Birthplace Va.

16 (a) Informant Alice M. Russell

(b) Address 399 N. 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/45 (month) (day) (year)

(c) Cemetery or crematory Hopewell

Location Hopewell Va

18 (a) Funeral director Lilly & Zeiler Inc

(b) Address 403 E. Broadway

(c) Huntington Williams, M.D. Registrar

JAN 17 1945 (Date filed by Registrar)

MEDICAL CERTIFICATION A

20. DATE OF DEATH JANUARY 17 1945, at 8.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 25 1944 to JANY 17 1945, and that I last saw h IM alive on JANY 17 1945.

	Duration
Immediate cause of death: PULMONARY TUBERCULOSIS	1935.
Due to: HEMORRHAGE OF LUNG JUNE 25	1944.
Due to: CARDIAC EXHAUSTION	1945.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NO
Major findings of operation: NONE
of autopsy: NO

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas P Chandler M. D.
Address #3013 ST PAUL ST Date signed JANUARY 17 1945

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21812 G21812

BALTIMORE CITY HEALTH DEPARTMENT X Registered No. 108

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item o. information should be carefully supplied. Do not age is especially important. Physicians: please write the te the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 Wahler way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stephen Havlicek Jr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 4 1944

8. AGE: Years	Months	Days	If less than one day
	9	12	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name STEPHEN HAVLICEK
13. Birthplace PENNA.

MOTHER
14. Maiden Name MARY STRUHAR
15. Birthplace BALTO. MD.

16 (a) Informant MARY HAVLICEK (MOTHER)
(b) Address 1207 WAHLER WAY

17 (a) BURIAL (b) Date thereof JAN. 19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly + Zeiler Sons
(b) Address 403 S. WOLFE ST.

19 JAN 17 1945 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-16- 1945, at 8 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12 1945 to 1-16 1945, and that I last saw him alive on 1-16 1945.

Immediate cause of death Febar Pneumonia — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M.S. Robertson M. D.
Address St Josephs Hosp Date signed 1-16-45

24813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24813

Registered No. 4747

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 141 No. Chapel St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 141 No. Chapel St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Charles Proctor

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M
5. Color or race Colored
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Alice Proctor
6 (c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) 11-10-1879
8. AGE: Years 65 Months 2 Days 5 If less than one day hr. min.
9. Birthplace Frederick Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Proctor
13. Birthplace Frederick Md.

MOTHER
14. Maiden Name Mary
15. Birthplace Frederick Md

16 (a) Informant Alice Proctor
(b) Address 141 No Chapel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 19 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location A.A. County Md

18 (a) Funeral director Mrs. Robert A. Ellwright
(b) Address 1129 N. Caroline Street

19 (a) JAN 17 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 19 45, at 8.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/13 19 45 to 1/15 19 45, and that I last saw him alive on 1/15 19 45

Immediate cause of death Lobar Pneumonia — Duration 1 wk.

Due to L

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Reynold B. Lightsolder M. D.
Address 2129 Druid Hill Ave Date signed 1/15/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24814

AB-89971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

193D

G24814

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days): 3mos-19days

(e) Length of stay in Baltimore (yrs., mos., or days): 40 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County:

(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No.: 1729 Gorsuch Ave.
(If rural give location)

(e) Citizen of foreign country?: (Yes or No)
If yes, name country:

3 (a) **FULL NAME** Lee Lang

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Chinese

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: ?

6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.): March 18-1884-or-1885

8. AGE: Years: 60 or 61 | Months: 9 | Days: 27 | If less than one day: hr. min.

9. Birthplace: California
(Town, county, and state)

10. Usual Occupation:

11. Industry or business:

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Baltimore City Hospitals(Records)

(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-45 (month) (day) (year)

(c) Cemetery or crematory: Lorraine

Location: Woodlawn

18 (a) Funeral director: Swann Memorial

(b) Address: 1081 W. Mulberry

JAN 17 1945 (Date rec'd by registrar) (b) Registrar

Huntington Hill

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14- 1945, at 5.40P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1944 to 1-14- 1945, and that I last saw him alive on 1-14- 1945.

Immediate cause of death: Carcinoma Pancreas

Due to:

Due to:

Other Conditions: Arteriosclerosis Pneumonia

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 8 ? 7

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury:

23. Signature: [illegible] M. D.

Address: Baltimore Md. Date signed 1-14-45

VS 150

G24815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G24815 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 234 Caton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) no
(e) Length of stay in Baltimore (yrs., mos., or days) over 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 234 Caton Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George Walter Eads
3 (b) If veteran, name war,
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Elenora Eads
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1876
8. AGE: Years 68 Months 5 Days 19 If less than one day hr. min.
9. Birthplace Jessups, Md (Town, county, and state)
10. Usual Occupation Trackman
11. Industry or business B & O R.R.

FATHER
12. Name Robert Eads
13. Birthplace ?

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Wm & Ed. Eads
(b) Address 807 Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mr. Winans

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) JAN 17 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1945, at 5a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1943 to Jan 14, 1945, and that I last saw h. alive on Jan 13 1945.

Immediate cause of death nephritis — Duration 4 mos

Due to C. hypertonitis — 24 yrs

Due to Arteriosclerosis — over 24 yrs

Other Conditions Cerebral hemorrhage (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. L. Camper M. D.
Address 639 N. Carey St Date signed 1-17-45

X

G24816
467189

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

(over) G24816
Registered No. 21a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 291 W. 31 St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Mindell A. Leonard.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-10-97

8. AGE: Years 48 | Months — | Days 5 | If less than one day ... hr. ... min.

9. Birthplace W. Va (Berkley Springs) (Town, county and state)

10. Usual Occupation Retired Ptr. Co

11. Industry or business Retired 3 years

FATHER 12. Name William Leonard

13. Birthplace W. Va

MOTHER 14. Maiden Name Lulu Spohn

15. Birthplace W. Va

16 (a) Informant Friends

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 18-1945 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3321 Falls Road

19 (a) JAN 17 1945 (Date rec'd by registrar) (b) [illegible] *Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 1945, at 7.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 13 1945 to Jan. 15 1945 and that I last saw him alive on Jan 15 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Toxicity (hyperpyrexia) due to antithetical use of DOCA	
Due to Addison's disease Tuberculosis of lung ? inactive	
Other Conditions TBC spine healed	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. M. Hattaway M. D.

Address J.H.H. Date signed 1-16

VS 150

G24817

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93 D

G24817 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John St.
(c) Hospital or institution: Women's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Brooklynville (If outside city or town limits, write RURAL and give town)
(d) Street No. Falls Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. FULL NAME MARY FRANCES JANES White

3 (b) If veteran, name war No | 3 (c) Social Security Account No. —

4. Sex: FEMALE | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frederick M. White

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan. 2-1862

8. AGE: Years 82 | Months — | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace New York, N.Y. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Edward P. Janes
13. Birthplace New York

MOTHER
14. Maiden Name Elizabeth B. —
15. Birthplace New York

16 (a) Informant Harding L. Roche
(b) Address Brooklynville, Md

17 (a) Removal - Burial (Burial, cremation, or removal) (b) Date thereof Jan 18-1945 (month) (day) (year)

(c) Cemetery or crematory Greenwood
Location Brooklyn, New York

18 (a) Funeral director Bubar Funeral Home
(b) Address 3631 Falls Road

19 (a) JAN 17 1945 (Date rec'd by registrar) (b) Huntington Mitchell Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1945, at 2.55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 29 1944 to Jan 17 1945, and that I last saw her alive on Jan. 17 1945.

Immediate cause of death: Postmin Coronary Occlusion — Duration

Due to: Arteriosclerotic HEART Disease

Due to: Arteriosclerosis, generalized

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. S. Gaud III M. D.
Address Women's Hospital Date signed 1-17-45

G24818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

15-7B

Registered No. G24818

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 717 LYNHURST ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 717 LYNHURST ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOAN CAROL ACKERMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) OCT 7-44

8. AGE: Years	Months	Days	If less than one day
	3	10	hr. min.

9. Birthplace BALTO MD
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name GEORGE J. ACKERMAN
13. Birthplace BALTO MD

MOTHER
14. Maiden Name MARY MEAGHER
15. Birthplace BALTO MD

16 (a) Informant GEORGE J. ACKERMAN
(b) Address 717 LYN HURST ST.

17 (a) BURIAL (b) Date thereof JAN 18-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL CEM
Location BALTO MD

18 (a) Funeral director Bernard C Hurle
(b) Address 121 E 41st ST

19 JAN 17 1945 Washington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1945, at 4-A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1944 to Jan 17 1945, and that I last saw h[illegible] alive on Jan 10 1945.

Immediate cause of death. Meningitis — Duration 1 day

Due to Otitis Media — 3 Months

Due to

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James A Colpoys M.D.
Address 5th Medical Area Date signed 1/17/45

VS 150

G24819 G24819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be answered or information should be carefully supplied. Be sure that the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere
(c) Hospital or institution: Levindale Home 415
(d) Length of stay in hospital or inst. (yrs., ~~mos., or days~~)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2600 Violet Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATE SHUMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~.
F	W	Widow

6 (b) Name of husband or wife Wolf Shuman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
84			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name — Bergowitz
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant Lawrence Shuman (Son)
(b) Address 2600 Violet Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Levin Inc
Address 1739 E. Balto St
JAN 17 1945
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 1945, at 9:12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1945, to Jan. 16 1945, and that I last saw h. alive on Jan. 16 1945.

Immediate cause of death Cerebral hemorrage — Duration
Due to Cerebral arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mary Nagel for Dr. A. E. Goldstein M. D.
Address Levindale Home Date signed 1-16-45

G24820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164a

G24820 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital-Dor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 328 Mt. Olivet Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Losch

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-05-8006

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Rosa Losch

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) July 4 1886

8. AGE: Years 58 | Months 6 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Carl Losch
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta Hoffmann
15. Birthplace Germany

16 (a) Informant Emil Losch - Brother
(b) Address 1808 Mayfield Ave. Halethorpe Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 18, 1945 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Baltimore City, Md.

18 (a) Funeral director Dill Bros.
(b) Address 3109 Frederick Ave.

19 (a) 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/13 1945, at 1:05 P M

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Suicide - Hanging - rope

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11:30 A. M. at 1-16-45 M.
(b) Where did injury occur? In the woodshed of above address
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hanging from rafter by rope

23. Signature [illegible] M.D. Medical Examiner.
Date signed 1/15/45

VS 151

Please write the causes of death clearly and legibly. Physicians: please write the exact age as especially important.

G24821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95C

G24821 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6319 Belair Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6319 Belair Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley J. Holewinski

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of ~~husband~~ or wife Katherine Ratajczak
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1873

8. AGE: Years	Months	Days	If less than one day
71 yrs.	2	21	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name John Holewinski
13. Birthplace Poland

MOTHER
14. Maiden Name Kurlinski
15. Birthplace Poland

16 (a) Informant Mrs. Katherine Holewinski
(b) Address 6319 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) [illegible] (b) [illegible]

JAN 17 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 45, at 4 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 45 Jan 18 45, and that I last saw h[illegible] alive on Jan 12 1945.

Immediate cause of death	Duration
Senility	
Due to Cerebral Hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Knox Emsley M. D.
Address 2536 E Balt Date signed 1-17-45

X

G24822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24822 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2875 W Lafayette
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 da
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2875 W Lafayette Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Cascio

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5 1893

8. AGE: Years 51 | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Fireman Asbestos Cleaning

11. Industry or business Ft Pageth City

FATHER
12. Name Samuel Cascio
13. Birthplace Italy

MOTHER
14. Maiden Name Not Known
15. Birthplace Italy

16 (a) Informant Mrs Catherine Cascio
(b) Address 2875 W Lafayette

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-45 (month) (day) (year)

(c) Cemetery or crematory Carlton Hill
Location Balto Md

18 (a) Funeral director Joyce A Farley
(b) Address Fulton & Lafayette

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JAN 17 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14 1945, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 28 1944 to Jan 14 1945, and that I last saw him alive on Jan 14 1945.

Immediate cause of death Acute alcoholism — Duration 7 days

Due to

Due to

Other Conditions Chronic myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Horak M. D.
Address 101 W. Read St Date signed 1.17.45

724

Howard

G24823 BALTIMORE CITY HEALTH DEPARTMENT G24823
CERTIFICATE OF DEATH 46E Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 So. Patterson Pk. Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Odenton, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. No number
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl B. Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Frances Howard

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) June 8, 1903

8. AGE: Years 41 | Months 7 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Poultryman

11. Industry or business Farm.

FATHER
12. Name James Samuel Howard
13. Birthplace Maryland

MOTHER
14. Maiden Name Johanna M. Mahle
15. Birthplace Germany

16 (a) Informant Mrs Frances Howard
(b) Address Odenton, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/ (month) (day) 45 (year)
(c) Cemetery or crematory Waugh Chapel Cem
Location Odenton Md.

18 (a) Funeral director John F Hennegan & L Lees
(b) Address 715 Light St

19 JAN 17 1945 (Date registered) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 1945; at 8:49 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1945, to Jan 16 1945, and that I last saw him alive on Jan 16 1945.

Immediate cause of death: Carcinoma of Colon Sigmoid — Duration: 4 mo

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James F. Kavanagh M.D. M. D.
Address 3328 N. Eden St Date signed 1-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24824 Registered No. 12B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1420 Jackson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 Jackson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Roland L. Boswell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Elizabeth C. Boswell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1918

8. AGE: Years	Months	Days	If less than one day
26 25	3	8	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Filling station operator
11. Industry or business

FATHER
12. Name Jesse M. Boswell
13. Birthplace North Carolina

MOTHER
14. Maiden Name Ada B. Abbitt
15. Birthplace Md.

16 (a) Informant Mrs. Elizabeth C. Boswell
(b) Address 1420 Jackson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 18, 1945 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St.

19 (a) 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14/45 19 , at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 44 to 1/14 19 45, and that I last saw h alive on 19

Immediate cause of death	Duration
Pulmonary Tuberculosis	3 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M. D.
Address 1225 Eutaw Date signed 1/16/45

G24825 G24825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2933 Woodland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2933 Woodland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter B. Dudderar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Grace

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) May 14 1874

8. AGE: Years 70 | Months 8 | Days – | If less than one day: hr. min.

9. Birthplace Unionville, Frederick Co. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business RR

FATHER 12. Name George Dudderar
13. Birthplace Maryland

MOTHER 14. Maiden Name Laura Butler
15. Birthplace Maryland

16 (a) Informant Walter Amick Dudderar
(b) Address 925 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. End of North Ave

18 (a) Funeral director John B. Denny & L. Sheets
(b) Address 715 Light St

19 (a) JAN 17 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14th 1945, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1944 to Jan 14 1945, and that I last saw h~~im~~ alive on Jan 14 19 45

Immediate cause of death. Angina Pectoris — Duration: ?

Due to Arteriosclerosis — Duration: ?

Due to — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John D Berlert M. D.

Address 4863 Park Heights Av Date signed 1/16/45

PRINT WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

24826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G24826 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4022 Duvall Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4022 Duvall Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: SARAH ANNE GRAHAM

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frederick C. Graham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 20, 1882

8. AGE: Years 62 | Months 8 | Days 27 | If less than one day: hr. min.

9. Birthplace: Grafton, W. Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Robert Thomas Knotts, Sr.
13. Birthplace: Grafton, W. Va.

MOTHER
14. Maiden Name: Mathide Lucas
15. Birthplace: Grafton, W. Va.

16 (a) Informant: Mr. Frederick C. Graham
(b) Address: 4022 Duvall Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/18/45 (month) (day) (year)
(c) Cemetery or crematory
Location: Grafton, W. Va.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 JAN 17 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 17, 1945, at 4:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1944 to Jan. 17 1945, and that I last saw h.m alive on Jan. 17 1945

Immediate cause of death: Cerebral Vascular Accident — Duration: Several Weeks

Due to: Hypertension and Arteriosclerosis — Duration: Abt 2 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Katherine N. Bonkowski M.D. M. D.

Address: 1011 N. Charles St. Date signed 1-17-45

X

Butter/x G24827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 8013

Registered No. G24827

G24827

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] (b) County York.
(c) City or town Hanover.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 28 George St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Rutter.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Walter Rutter
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 17 1902

8. AGE: Years 42 | Months 2 | Days 0 | If less than one day ____ hr. ____ min.

9. Birthplace Hanover Pa.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business Works in Hanover Cowlage

FATHER
12. Name Walter Rutter
13. Birthplace Hanover Pa.

MOTHER
14. Maiden Name Rosie Teal
15. Birthplace Hanover Pa.

16 (a) Informant Mercy Hospital per M.O.
(b) Address Saratoga & Calvert Sts Balto Md

17 (a) Removal (b) Date thereof Jan 19 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Hanover Pa

18 (a) Funeral director W. A. Feser
(b) Address Hanover Pa.

(c) JAN 17 1945 (Date received by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1945, at 2:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1944, to Jan 17 1945, and that I last saw h[illegible] alive on 1/17/45 19____

Immediate cause of death	Duration
Respiratory Failure	
Due to Encephalo Myelitis	4 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Multiple metastatic abscess

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. F. Habelmann M. D.
Address Mercy Hosp. Balto Date signed 1/17/45

X

G24823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46-H Registered No. G24823

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2445 Woodbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2445 Woodbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George T. Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Ada Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
49 48			hr. min.

9. Birthplace Shelltown, Md. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Frank Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Brittain
15. Birthplace Md.

16 (a) Informant Ada Smith
(b) Address 2445 Woodbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave.

JAN 18 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14- 1945 at 8.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27- 1944 to 1-14- 1945, and that I last saw alive on 1-14- 1945

Immediate cause of death	Duration
Sarcomatosis	3 mos.
Due to Lymphosarcoma of Mesentary & Retroperitoneum	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9-27-44
Major findings of operation: Lymphosarcoma of Mesentary & Retroperitoneum
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bosman Wiggins M. D.
Address 2243 Madison Ave. Date signed 1-17-45

VS 150

G24820

AB-91255

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

20

Registered No. G24820

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 921 Jordan St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25-1874

8. AGE: Years 70 | Months 11 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Daniel Clark

13. Birthplace Va.

MOTHER 14. Maiden Name Lucinda Lindsey

15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Records)

(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/17/45 (month) (day) (year)

(c) Cemetery or crematory Danville Va

Location Danville

18 (a) Funeral director Joseph E. Foster

(b) Address 334 N. Central Ave

19 JAN 18 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13- 1945 at 7.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23 1944, to 1-13- 1945, and that I last saw him alive on 1-13- 1945.

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions Cystitis, epididymitis, (TB) Orchitis (TB), Urethritis prostatitis hydronephrosis, pyelonephritis.

Date of operation

Major findings of operation:

of autopsy Same as above pyelonephritis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm Kenneth Smith M. D.

Address Balt. City Hosp. Date signed 1/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

107

G24830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

Registered No. G24830

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1123 Forrest st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 Forrest st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Shipley

3 (b) If veteran, name war —

3 (c) Social Security Account No. 717-07-8759

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Laura L. Shipley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6 1869

8. AGE: Years	Months	Days	If less than one day
75	7	11	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired Engineer
11. Industry or business Pa. R. R.

FATHER
12. Name Chas. W. Shipley
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Martin
15. Birthplace Md.

16 (a) Informant Wallace W. Shipley
(b) Address 1123 Forrest St.

17 (a) Balto (Burial, ~~cremation or removal~~) (b) Date thereof 1/19/45 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location " Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) JAN 18 1945 (Date Rec'd by Registrar) (b) Huntington Willis, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17th 1945, at 11 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1945, to Jan 17 1945, and that I last saw him alive on Jan 16 1945.

	Duration
Immediate cause of death: Cerebral Hemorrhage.	10 days
Due to: Arteriosclerosis	
Due to:	
Other Conditions: Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. B. Stevens M. D.
Address 3400 Edmondson Ave. Date signed 1/17/45

VS 180

G24831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8/a ✓

G24831 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3129 ~~Longview~~ Ave (If rural give location)
(e) Citizen of foreign country ~~Germany~~ (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Mentzel

3 (b) If veteran, name war N/ | 3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ~~—~~ years

7. Birth date of deceased (mo., day, yr.) 4-30-30

8. AGE: Years	Months	Days	If less than one day
14	8	16	hr. min.

9. Birthplace Md. (Balto.) (Town, county, and state)
10. Usual Occupation Student
11. Industry or business Public School

FATHER
12. Name Harold Mentzel
13. Birthplace Md

MOTHER
14. Maiden Name Agnes Kunley
15. Birthplace Md

16 (a) Informant Ricardo -
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1/19/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Woodlawn
Location " Md

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul. st.

19 (a) JAN 18 1945 (Date Rec'd by Local Reg.) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1945 at 9 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1944 to Jan 16 1945 and that I last saw h ~~alive~~ on Jan 16 19 45

Immediate cause of death	Duration
Respiratory Failure	
Due to Meningo-encephalitis chronic, type undetermined	4 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Abraham Ravin M. D.
Address Johns Hopkins Date signed 1-16-45

VS 150

X

G21832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932 Registered No. G21832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 606 N. Mount
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 N. Mount
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Jordan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Lethia Jordan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25-1903

8. AGE: Years 41 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Taylor
13. Birthplace N. C

MOTHER
14. Maiden Name Maggie Jordan
15. Birthplace N. C

16 (a) Informant Lethia Jordan
(b) Address 606 N. Mount

17 (a) Burial (b) Date thereof Jan 20-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location North Carolina

18 (a) Funeral director Sam'l N. Chase Bro.
(b) Address 638 N. Mount St

19 (a) JAN 18 1945 (b)
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/16. 1945. at 7.14 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14/45 1945, to 1/16 1945. and that I last saw him alive on 1/16/45 19

Immediate cause of death

Due to Acute myocarditis 2 days
with Cerebral Hemorrhage 3 hrs.

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature J. F. Gunn M. D.

Address 26 Warrington Date signed 1/17/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24833 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2624 Cecil Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2624 Cecil Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin E.Hinkey

3 (b) If veteran, name war: ****
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: Wht.
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Caroline C.Hinkey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 8, 1866

8. AGE: Years 78 | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace A.A.County Md. (Town, county, and state)
10. Usual Occupation Hardwood Floor
11. Industry or business Contractor

FATHER
12. Name John M.Hinkey
13. Birthplace A.A.County Md.

MOTHER
14. Maiden Name Mary E.McKnew
15. Birthplace Maryland

16 (a) Informant Marguerite M.Hinkey
(b) Address 1936 W.Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 19, 1945 (month) (day) (year)
(c) Cemetery or crematory Baldwin Memorial
Location A.A.County Md.

18 (a) Funeral director Robert S.Little
(b) Address 2700 Edmondson Ave.

19 JAN 18 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945, to Jan 16 1945, and that I last saw him alive on Jan 15 1945.

Immediate cause of death	Duration
Myocarditis	1 yr.
Due to	
Due to	
Other Conditions Cerebral Arterio Sclerosis (Include pregnancy within 3 months of death)	2 yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jacob Fussler M. D.
Address 1823 N. Broadway Date signed 1/20/45

VS 150

24834 G24834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No. G24834

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 19

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.

(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Frederick Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Louis F. Burnell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 20, 1944

8. AGE: Years	Months	Days	If less than one day
		28	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER 12. Name Arthur B. Burnell

13. Birthplace Staunton Virginia

MOTHER 14. Maiden Name Edith P. Wilson

15. Birthplace Baltimore Md.

16 (a) Informant Edith P. Burnell

(b) Address 1618 Frederick Ave.

17 (a) Burial (b) Date thereof 1-19-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cem.

Location Baltimore Md.

18 (a) Funeral director Robt B. M. Watters

(b) Address Pratt & Shroeder Sts.

19 JAN 18 1945 (Date rec'd by registrar) (Huntington Williams M.D.)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1945, at 6:08 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Interstitial Pneumonia

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury..... at..... M.

(b) Where did injury occur?.....

(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....

(d) Means of injury.....

23. Signature Robert Lee Grafton M.D.
Medical Examiner.

Date signed 1-18-45

G21335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95C

G21833 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 720 Reservoir St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 720 Reservoir St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Bussey (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name Charles

13. Birthplace Bussey

14. Maiden Name Mary

15. Birthplace Bussey

16 (a) Informant Husband

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-45 (month) (day) (year)

(c) Cemetery or crematory Southern Ave
Location Southern Ave.

18 (a) Funeral director Jack Lewis Inc.

(b) Address 1439 E. Balto St

19 (a) JAN 18 1945 (Date rec'd by registrar) Huntington Wilson, Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-17-45 19 , at 8:40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 43 to Jan 17 19 45
and that I last saw her alive on Jan 7 19 45

Immediate cause of death Cardiac Insufficiency — Duration 3 mos

Due to Cardiac Hypertrophy — 5 years

Due to Coronary Thrombosis, Hypertension

Other Conditions Post-Cerebral Accidents

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sheldon Cooper M. D.

Address 2107 Park Ave Date signed 1/17/45

24836 ✓ G24836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 S. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State ✓ (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 S. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME William Morris Tracey Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-1450

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Margaret W. Streater
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 13, 1878

8. AGE: Years	Months	Days	If less than one day
66	1	1	hr. min.

9. Birthplace ~~Carpenter~~ Balto. Md.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Baltimore Brass Co.

FATHER
12. Name William M. Tracey
13. Birthplace Md

MOTHER
14. Maiden Name Angelia Rider
15. Birthplace Penna

16 (a) Informant Mrs Margaret W. Tracey
(b) Address 1312 S. Carey St
17 (a) Burial (b) Date thereof 1/18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd
18 (a) Funeral director Harry A. Wilke
(b) Address 4101 Edmondson Ave
19 (a) Date rec'd by registrar JAN 18 1945 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14/1945 at 6 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-19 1944 to 1-14 1945 and that I last saw h~~im~~ alive on 1/14 1945

Immediate cause of death Bronchio-Pneumonia terminal — Duration 2/12/45
Due to Cerebral Hemorrhage 11/19/44
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph G. Landcastle
Address 1909 Washington Blvd Date signed 1/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107 Registered No. G24837

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4812 Palmer Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4812 Palmer Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Guilford D Ridgely

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Martha Sullivan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 24 1857

8. AGE: Years 87 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER 12. Name Wm C Ridgely
13. Birthplace Maryland

MOTHER 14. Maiden Name Elmira Slate
15. Birthplace Maryland

16 (a) Informant Mrs Raymond Cumbacker
(b) Address 4812 Palmer Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 20 45 (month) (day) (year)
(c) Cemetery or crematory Hampstead
Location Cranall Co. Md

18 (a) Funeral director Edward C Tipton
(b) Address Hampstead Md

JAN 18 1945 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1945 at 12 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to Jan 18 1945, and that I last saw him alive on Jan 18 1945

Immediate cause of death Bronchopneumonia — Duration 10 days

Due to Senility

Due to Arteriosclerosis

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J Mills M. D.
Address 5276 Park Heights Ave Date signed Jan 18 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be complete and correct as age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G24838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G24838

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 933 W. Franklin
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 933 W. Franklin
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Frances Whitley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C.	Widow

6 (b) Name of husband or wife William Whitley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1880

8. AGE: Years	Months	Days	If less than one day
64	9	10	hr. min.

9. Birthplace Middlesex Co. Va.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Bristol Foreman
13. Birthplace Va.

MOTHER
14. Maiden Name Maria ?
15. Birthplace Va

16 (a) Informant Margaret Bland
(b) Address 933 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. City

18 (a) Funeral director Raymond W. Chance & Son
(b) Address 638 N. Gilmor St

19 (a) 1/18/45 (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 1945, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1945 to Jan 16 1945 and that I last saw alive on Jan 16 1945.

Immediate cause of death	Duration
Cardiac Decompensation	6 Mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Watts M. D.
Address 515 Cathedral St Date signed 1/17/45

G24839 ✓ G24839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B Registered No.

Very item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 113 N. Chester St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 N Chester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Karasanski or Karanaugh

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife Frank F.

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Nov 26, 1894

8. AGE: Years	Months	Days	If less than one day
50	1	20	hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name John Karanaugh

13. Birthplace Balto.

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Frank Karasanski

(b) Address 113 N. Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/45 (month) (day) (year)

(c) Cemetery or crematory St. Redeemer

Location Belair Rd.

18 (a) Funeral director W. W. E. Dippel & Son

(b) Address Lombard & Eden Sts

19 (a) JAN 18 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1945, at 2:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to Jan 16 1945, and that I last saw her alive on Jan 16 1945.

Duration
Years
1 yr

Immediate cause of death Pulmonary Abscess

Due to Cirrhosis Liver (Hepatic) Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward J. Dempsey M.D.

Address 1000 E. Fayette Date signed 1/19/45

VS 150

G24810 ✓ G21810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 111-C

Registered No.

Type or print all items or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 S. Madeira St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 65

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Gaston
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 S. Madeira St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Stadter

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Barbara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 17 1869

8. AGE: Years 75 | Months 11 | Days 28 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George Stadter
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Ruder
15. Birthplace Germany

16 (a) Informant Theresa Stadter
(b) Address 114 S. Madeira St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/45 (month) (day) (year)
(c) Cemetery or crematory H. Rodeemer
Location Belair Rd.

18 (a) Funeral director W. A. E. Applebaum's Sons
(b) Address Broadway & Aliceanna Sts.

19 (a) (Date rec'd by registrar) JAN 19 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1945 at 7:P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1945 to Jan 15 1945; and that I last saw him alive on Jan 15 1945.

	Duration
Immediate cause of death: Hypostatic Pneumonia	4 days
Due to: Shock changes	—
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George D. Lefferty M. D.
Address 432 S. Patterson Pk. Date signed 1/16/45

VS 150

G24811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

G24811 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. Rutland Ave
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 - 13
(e) Length of stay in Baltimore (yrs., mos., or days) 33

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2531 Quantico Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Gold

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rebecca -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (town, county, and state)

10. Usual Occupation Retired Tailor

11. Industry or business

FATHER 12. Name Abraham Gold
13. Birthplace Russia

MOTHER 14. Maiden Name Rachael -
15. Birthplace Russia

16 (a) Informant Rebecca Gold
(b) Address 2531 Quantico Ave

17 (a) Burial | (b) Date thereof 1-18-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pikesville
Location

18 (a) Funeral director Jacob Levin Inc
(b) Address 1429 E. Baltimore St

JAN 18 1945 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-17 1945, at 11:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-12 1944, to 1-17 1945, and that I last saw h... alive on ... 19...

Immediate cause of death: cardiorespiratory failure — Duration
Due to: Cerebral embolism (?)
Due to:
Other Conditions: Coronary insufficiency (include pregnancy within 3 months of death)
Date of operation 12-13-44
Major findings of operation: Benign prostatic hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Myron J. Myers M. D.
Address Sinai Hospital Date signed 1-18-45

PRESS WRITING FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G24812 ✓ G24812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2106 Woodbourne Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2106 Woodbourne Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Mary Eberwein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 26 - 1860

8. AGE: Years	Months	Days	If less than one day
84	1	21	hr. min.

9. Birthplace Phila Pa (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name George Ketterer
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Huber
15. Birthplace Germany

16 (a) Informant Mr William Eberwein
(b) Address 1984 Elston St. Phila Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-45 (month) (day) (year)
(c) Cemetery or crematory Northwood Mem
Location Phila Pa.

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150
JAN 18 1945

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/17/ 1945, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944, to 1/17/ 1945, and that I last saw h[illegible] alive on 1/17 1945.

Immediate cause of death Carcinoma of Breast. Generalized Carcinomatosis. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Burke Boyle. M. D.
Address 5217 Harford Rd. Date signed 1/17/45
Balto. md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G24813 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town [redacted] Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4523 Mansfield ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella May Matthews

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh.	W.

6 (b) Name of husband or wife Isaac H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14 1899

8. AGE: Years	Months	Days	If less than one day: hr.	min.
65	3	4		1879

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Wm W. Groves
13. Birthplace Md

MOTHER
14. Maiden Name Clara M. Evans
15. Birthplace Md

16 (a) Informant Mr. Isaac H. Matthews
Address 4523 Mansfield Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-45 (month) (day) (year)
(c) Cemetery or crematory
Location Loudon Park
18 (a) Funeral director L. J. Ruck
(b) Address 5306 Harford R
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-18 1945, at 8:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1945, to 1-18 1945, and that I last saw her alive on 1-18 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to

Due to: Hypertension arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. B. Robertson M. D.
Address St. Josephs Hospital Date signed 1-18-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JAN 23 1945 VS-110

G24814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V157-E

Registered No. G24814

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St + Calvert St
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-1
(e) Length of stay in Baltimore (yrs., mos., or days) Native

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore, City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3961 Willoby Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joanne Mary Butt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 7, 1945

8. AGE: Years | Months | Days: 10 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Giles Rhein Butt
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Ruth Roeder
15. Birthplace Baltimore, Maryland

16 (a) Informant Giles Rhein Butt
(b) Address 3961 Willoby Ave, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-45 (month) (day) (year)
(c) Cemetery or crematory
Location Holy Redeemer

18 (a) Funeral director L. J. Rusk
(b) Address 4305 Hamilton Rd

19 (a) (Date rec'd by registrar) JAN 19 1945 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17, 1945, at 3:11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 16, 1945, to January 17, 1945, and that I last saw her alive on January 17, 1945

Immediate cause of death: Cardio-respiratory Failure — Duration: 10 days

Due to: Congenital Heart disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Pulmonary artery atresia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Frank Supplee, III

Address Union Memorial Hos Date signed 1/17/45 M. D.

Huntington Md

X

G24815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1108 Registered No. G24815

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 808 Hanover
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 808 Hanover
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ann Merrick

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Benj. Merrick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1861

8. AGE: Years 83 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Bettie Coates
(b) Address 808 Hanover

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 18-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Jennie A Adams
(b) Address 1443 Mosher St

19 (a) JAN 18 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1945, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 - 1945, to Jan 15 1945, and that I last saw her alive on Jan 14 1945.

Immediate cause of death	Duration
acute Lobar Pneumonia	
Due to 2 mos.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 1 [illegible] Ave N Date signed 1/17/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G24846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G24846

Please write plainly, with pen and ink. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3414 E. Baltimore St.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3414 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Zeller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1863

8. AGE: Years 81 | Months 6 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Andrew Zeller
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Schultz
15. Birthplace Germany

16 (a) Informant Barbara M. Hutchins
(b) Address 3414 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/45 (month) (day) (year)
(c) Cemetery Swartz First Evangelical
Location O'Donnell St., Baltimore

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) JAN 18 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15 1945, at 8.55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5, 1945 to Jan. 15, 1945 and that I last saw her alive on Jan. 15, 1945

Immediate cause of death: Myocarditis (chronic) — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene L. Cusanno M. D.
Address 2314 E. Baltimore St. Date signed 1/17/45

VS 150

G24817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

330

G24817 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 Seagull ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Seagull ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Lake Keene

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col.	Married

6 (b) Name of husband or wife Bertha Keene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/28/1892

8. AGE: Years	Months	Days	If less than one day
52 53	10	17	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William J. Keene
13. Birthplace Eastern Shore, Md.

MOTHER
14. Maiden Name Williamina Caphas
15. Birthplace Eastern Shore, Md.

16 (a) Informant Bertha Keene
(b) Address 403 Seagull Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-45 (month) (day) (year)
(c) Cemetery or crematory Smith Ville
Location Eastern Shore

18 (a) Funeral director Raymer Sanders
(b) Address 1412 E. Preston Street

19 (a) JAN 18 1945 (Date rec'd by registrar) (b) Hunter for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15- 1945 at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1945 to 1-14 1945 and that I last saw h[illegible] alive on 1-14 1945

Immediate cause of death	Duration
Lobar Pneumonia	5 days
Due to La Grippe	14 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Walters M. D.
Address 1443 E. Eager Date signed 1-17-45

VS 180

The information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G24818

1. PLACE OF DEATH: 539 Oxford St
(a) Baltimore City, Maryland
(b) Street address 539 Oxford St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 539 Oxford St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Moses Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Alice Brooks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-10-1857

8. AGE: Years 87 | Months 5 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace Calvert Co. Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Frank Brooks
13. Birthplace Calvert Co. Md

MOTHER
14. Maiden Name Margaret
15. Birthplace Calvert Co. Md

16 (a) Informant Daisy Brooks
(b) Address 539 Oxford St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 18, 1945 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Catonsville, Md.

18 (a) Funeral director Mrs Katie R Williams
(b) Address 1542 N Schroeder St.

19 (a) JAN 18 1945 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1945 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1945 to Jan 15 1945 and that I last saw him alive on Jan 13 1945

Immediate cause of death: Acute Congestive Heart Failure — Duration

Due to Bronchial Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius Blakistone M.D.
Address 1543 Pennsylvania Ave Date signed 1-18-45

X

Please write the causes of death clearly and legibly. Physicians: please write in the space below the causes which gave rise to the immediate cause (a), stating the underlying cause last. The correct age is especially important. Physicians are requested to supply information for items 20 to 23, inclusive.

G21819 466463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312 Registered No. G21819

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 N. Broadway
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1326 Holbrook St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Meinl (Anna Meinl)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Anton Meinl
6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.) 6-14-70

8. AGE: Years 74 | Months 7 | Days 3 | If less than one day: hr. min.

9. Birthplace Balto: Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John J. Meyer Sr.
13. Birthplace Germany.

MOTHER
14. Maiden Name Elizabeth Hahn
15. Birthplace Germany

16 (a) Informant Record.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 20, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

Nov 8 1945

MEDICAL CERTIFICATION A

20. DATE OF DEATH Jan-17- 1945, at 5.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-30 1944, to Jan-17 1945, and that I last saw h[illegible] alive on Jan 17 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertension cardio-vascular renal dis.	
Due to	
Other Conditions Cataract rt. eye, cataract cat. l. eye. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Whitbeck M. D.
Address JHH. Date signed 1-17

G21850 G21850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1926 N. Washington St D.O.A
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1926 N. Washington
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Freyman

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	717-07-8922

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Ida Elenor Freyman (nee Burmingham) 6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Jan. 6th 1875

8. AGE: Years	Months	Days	If less than one day
70	0	11	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired - Clerk
11. Industry or business Penna. R.R. Co.

FATHER
12. Name Conrad Freyman
13. Birthplace Germany

MOTHER
14. Maiden Name Do not Know
15. Birthplace Staunton Va.

16 (a) Informant Mrs. Ida E. Freyman
(b) Address 1926 N. Washington St.

17 (a) Burial (b) Date thereof Jan 20th 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. Md.

18 (a) Funeral director Geo. Weber & Son
(b) Address 2503 Edmondson Ave

19 (a) JAN 18 1945 Huntington Williams
(Date rec'd by Local Registr.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/17/45 at 10:15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection - Autopsy, Inspection or Inquiry thereon, and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Charles J. Pulaski M.D. Medical Examiner.
Date signed 1/17/45

VS 151

G2485 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

G2485 1 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2544 Aruna h Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 D
(e) Length of stay in Baltimore (yrs., mos., or days) 38 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2544 Aruna h Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Della Longabaugh CALLET

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife William H.
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Mar. 25th 1892

8. AGE: Years	Months	Days	If less than one day
52	9	23	hr. min.

9. Birthplace St. Mary's Co. Md (Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Paul Goldsborough
13. Birthplace St. Mary's Co. Md

MOTHER
14. Maiden Name Callet
15. Birthplace St. Mary's Co

16 (a) Informant Mr. Wm. Longabaugh
(b) Address 2544 Arunah Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 (month) 20 (day) 45 (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director Geo. Weber & Son
(b) Address 2503 Edmondson Ave

19 (a) (Date rec'd by Registrar) JAN 18 1945 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/17 1945 at 11:40 P.M.

21. I certify that I took charge of the remains described above, held an Inquest (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph B. McNally M.D. Medical Examiner.
Date signed 1/18/45

X

G24852 G24852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1308 Eutaw Place
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George C. Frederick

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 30th 1864

8. AGE: Years	Months	Days	If less than one day
80	1	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation (Retired)
11. Industry or business —

FATHER
12. Name Charles Frederick
13. Birthplace Md

MOTHER
14. Maiden Name —
15. Birthplace Md

16 (a) Informant Mrs. Grace Schneider
(b) Address 1308 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 19-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director F. C. Kleinhat & Son
(b) Address 300 Eutaw Place

JAN 18 1945 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16th 1945 at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 8 1945 to Jan. 16 1945 and that I last saw him alive on Jan. 15 1945

Immediate cause of death	Duration
Chronic Myocarditis	2Yrs
Arteriosclerosis	5Yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2757 W Mount Date signed 1/17/45

G24853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G24853 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2927 N. Calvert Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 76 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2927 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Alice T. Walker

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henry M. Walker
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) July 1 ---- 1868

8. AGE: Years 76 | Months ---6 | Days --16 | If less than one day -- hr. --- min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: ------

FATHER
12. Name: James J. McMahon
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Bridget Dooley
15. Birthplace: Ireland

16 (a) Informant: Henry M. Walker
(b) Address: 2927 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/45 (month) (day) (year)
(c) Cemetery or crematory: Green Mount
Location: Baltimore, Md.

18 (a) Funeral director: H. A. Mears and Son
(b) Address: 805 N. Calvert Street

19 (a) JAN 18 1945 (Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 17 1945, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944, to Jan 17 1945, and that I last saw him alive on Jan. 17 1945.

	Duration
Immediate cause of death: Cardio-Renal Hypertension	10 yr
Due to: Renal Arteriosclerosis.	
Due to: Sudden coronary occlusion.	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation: ------
Major findings of operation:
of autopsy: ------

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John T. Amara M. D.
Address: 80 Centre St. Date signed: Jan 18/45

G24854 G24854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124-B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.a

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 21 N. Chase Street
(If rural give location)
(e) Citizen of foreign country? --------- (Yes or No)
If yes, name country ---------

3 (a) **FULL NAME** Catherine Baker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Herbert Baker
6 (c) If alive, give age --years

7. Birth date of deceased (mo., day, yr.) ---------- 1845

8. AGE: Years	Months	Days	If less than one day
50	---	---	-- hr. -- min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business -------

FATHER
12. Name ---------
13. Birthplace Germany

MOTHER
14. Maiden Name Not obtainable
15. Birthplace Germany

16 (a) Informant S. R. Mears
(b) Address 805 N. Calvert Street

17 (a) Burial (b) Date thereof 1/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Paul's Reformed
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) JAN 18 1945 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-16- 1945, at 3-55 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fatty degeneration of Liver

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walden M.D.
Medical Examiner.
Date signed 1-17-45

VS 151

G24855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 129

G24855 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3322 5t.

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 624 Berry St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Wallace Daniel Stevens

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-01-4076

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs Nellie Stevens

6 (c) If alive, give age 2 years

7. Birth date of deceased (mo., day, yr.) March 19, 1900

8. AGE: Years	Months	Days	If less than one day
44	9	26	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER 12. Name John Stevens

13. Birthplace Maryland

MOTHER 14. Maiden Name Blanche Kraut

15. Birthplace Maryland

16 (a) Informant Mrs. Nellie Stevens

(b) Address 624 Berry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 19/45 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Federal Road

18 (a) Funeral director Ebenezer B Donovan

(b) Address 3615 Harford Ave

19 (a) 1945 (Date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-16 1945 at 6:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-18 1944 to 1-16 1945.

and that I last saw h/M alive on 1-16 1945.

Immediate cause of death Cardiorespiratory failure — Duration

Due to Peritonitis

Due to Chronic gastritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Melchizah Spragins

Address UMH Date signed 1-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G24856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G2[illegible]6

Registered No. [illegible]

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 22 S. Athol Ave.

(c) Hospital or institution: German Aged People Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County [illegible]

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 22 S. Athol Ave.

(If rural give location)

(e) Citizen of foreign country? [illegible] (Yes or No)

If yes, name country [illegible]

3 (a) FULL NAME Josephine Harp

3 (b) If veteran, name war [illegible]

3 (c) Social Security Account No. [illegible]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widow

6 (b) Name of husband or wife late Wm A.

6 (c) If alive, give age [illegible] years

7. Birth date of deceased (mo., day, yr.) June 21/1859

8. AGE: Years	Months	Days	If less than one day
85	6	25	hr. [illegible] min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation [illegible]

11. Industry or business [illegible]

FATHER

12. Name John Bidlingmayer

13. Birthplace Germany

MOTHER

14. Maiden Name Margaret Fitzgerald

15. Birthplace Ireland

16 (a) Informant German Aged People Home

(b) Address 22 S. Athol Ave.

17 (a) Burial (b) Date thereof 1/19/45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Greenmount Ave. & 31st St.

18 (a) Funeral director Henry W. Nitzke

(b) Address 4101 Edmondson Ave.

19 (a) [illegible] (b) [illegible]

(Date received by Registrar) (Registrar)

JAN 18 1945

Huntington "Hi[illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1945, at 3.40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2/45 19[illegible], to Jan. 16/45, and that I last saw her alive on Jan. 15/45.

Immediate cause of death	Duration
Broncho-Pneumonia	3 days.
Due to [illegible]	
Due to [illegible]	Unknown.
Other Conditions Arterio Sclerosis.	

(Include pregnancy within 3 months of death)

Date of operation [illegible]

Major findings of operation: [illegible]

of autopsy: [illegible]

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide [illegible]

(b) Date of occurrence [illegible] at [illegible] M

(c) Where did injury occur? [illegible]

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? [illegible] While at work? [illegible]

(Specify type of place)

(e) Means of injury [illegible]

23. Signature Henry Wade Chenoweth M. D.

Address 930 Hanover Date signed Jan. 18/45

VS 150

97

G24857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945 D

Registered No. G24857

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Md. General Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 Harlem Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Raymond F. Carlin

3 (b) If veteran, name war: 2nd W.W.

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: widower.

6 (b) Name of husband or wife: Agnes Carlin

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 30, 1900

8. AGE: Years 44 ~~47~~ | Months 9 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Painter

11. Industry or business

FATHER
12. Name: Frank F. Carlin
13. Birthplace: Maryland.

MOTHER
14. Maiden Name: Alice Burhoe
15. Birthplace: Maryland

16 (a) Informant: Frank F. Carlin
(b) Address: 3457 Roland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 19/45 (month) (day) (year)
(c) Cemetery or crematory: St. Mary's
Location: Hampden

18 (a) Funeral director: Edmonds & Brooks
(b) Address: 3605-178 Hartford Ave

19 JAN 18 1945 (Date received by local registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION 45

20. DATE OF DEATH Jan 16 1945, at 8 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature: Robert L. Graham M.D. Medical Examiner.
Date signed Jan. 17 1945

VS 151

Cause of death is solemn, important. Physician: please write the cause of death clearly and legibly.

G24858 G24858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 12/29/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 12/29/44

2. USUAL RESIDENCE OF DECEASED:
(a) State N.J. (b) County
(c) City or town Bivalve
(If outside city or town limits, write RURAL and give town)
(d) Street No. -
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** RICHARD HARRIS

3 (b) If veteran, name war -

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Georgianna Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1870

8. AGE: Years	Months	Days	If less than one day
74	2	24	hr. min.

9. Birthplace Brooklyn, N. Y.
(Town, county, and state)
10. Usual Occupation Cook
11. Industry or business Merchant Marine

FATHER
12. Name Martin Harris
13. Birthplace Germany

MOTHER
14. Maiden Name Marie ?
15. Birthplace Switzerland

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof Jany 20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Port Norris N.J.
Location

18 (a) Funeral director John Crutchfield Sons
(b) Address 1900 Eutaw Place

(Date rec'd by registrar) JAN 18 1945 (b) Huntington Williams, M.D.

VS 150

Cremation authorized by letter from hospital.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18, 1945, at 5:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 29 1944, to Jan. 18 1945, and that I last saw him alive on Jan. 18 1945.

Immediate cause of death 1. Arteriosclerotic heart disease; 2. Hypertrophy of prostate, benign with uremia, secondary to urinary tract obstruction, mild.
Other conditions: Asthma; Cystitis chronic; Generalized Arteriosclerosis; Ventricular fibrillation; wound of thorax, penetrating.
(Include pregnancy within 3 months of death)

Duration
(over)

Date of operation None
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams
Address Baltimore Md. Surgeon, USPHS, Executive Office Date signed 1/18/45 M.D.

MS-57873

Cause of death are is especially important. Physicians: please write the causes of death clearly and legibly.

G24859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G24859 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 1/5/45
(e) Length of stay in Baltimore (yrs., mos., or days) Since 1/5/45

2759

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4900 Hillen Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME YELLOTT, Lisette Augusta

3 (b) If veteran, name war -
3 (c) Social Security Account No. -

4. Sex Femal XXXXX
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Dulaney Yellott
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 11, 1890
8. AGE: Years 54 | Months 1 | Days 7 | If less than one day hr. min.
9. Birthplace Philmore County, Minn. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business -

FATHER
12. Name August Fluegel
13. Birthplace Minn.

MOTHER
14. Maiden Name Helen Erdman
15. Birthplace Minn.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27-1945 (month) (day) (year)
(c) Cemetery or crematory Trinity Episcopal
Location Longreen Md.

18 (a) Funeral director Clayer E. Arthur
(b) Address York Md.

19 (a) JAN 18 1945 (Registrar) (b) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Jan. 18, 1945 at 9:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5, 1945, to Jan. 18, 1945, and that I last saw him alive on Jan. 18, 1945.

Immediate cause of death	Duration
Carcinoma of the stomach with extensive abdominal metastases	Unk.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None this admission
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Arthur M. D.
Address Baltimore, Md. Surgeon, USPHS, Executive Officer Date signed 1/18/45

Medical Study-NCA-58041

G24850
AB-91525

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G24850

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 N. Durham St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Steiner

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. ?2-1896

8. AGE: Years 48 | Months 11 | Days 14? | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Vincent Steiner
13. Birthplace Europe

MOTHER
14. Maiden Name Maria ?
15. Birthplace Europe

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-46 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Salt Mill

18 (a) Funeral director Mark Bros. Bday
(b) Address 700 E. Eberbach

JAN 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16- 1945, at 11.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1945, to 1-16 1945, and that I last saw h im alive on 1-16- 1945.

Immediate cause of death: Miliary tuberculosis — Duration: 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto City Hosp Date signed 1/23/45

C21861 ✓ C21861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3720 Hudson Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 69
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3720 Hudson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELIZABETH LANG

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frederick C. Lang
6 (c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1871

8. AGE: Years 73 | Months 11 | Days 11 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Thomas Hoyt
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Ireland

16 (a) Informant FREDERICK C. LANG
(b) Address 3720 Hudson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-45 (month) (day) (year)
(c) Cemetery or crematory First Evangelical Cem.
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) (Date rec'd by registrar) JAN 19 1945 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION A. M.

20. DATE OF DEATH Jan. 16 1945, at 11.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/13 1945 to 1/16 1945 and that I last saw her alive on 1/16/45 19

Immediate cause of death	Duration
Acute Cardiac dilatation	
Due to Chronic nephritis — Chronic passive congestion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature H. H. Lovell M. D.
Address 635 S. Conkling Date signed 1/17/45

G24852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G24852

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Caroline Sts
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2201 W. Pratt St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad A. Stolzenbach

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillian A. Stolzenbach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 6-1898

8. AGE: Years	Months	Days	If less than one day hr.	min.
46	3	12		

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Produce Dealer

11. Industry or business Self

FATHER
12. Name Henry Stolzenbach
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary McKnew
15. Birthplace Maryland

16 (a) Informant Mrs. Lillian A. Stolzenbach
(b) Address 2201 W. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 22-1945 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md.

18 (a) Funeral director George L. Schwatt
(b) Address 2101 Fredrick Ave

19 JAN 19 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/17/1945 at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/17/1945 to 1/17/1945 and that I last saw him alive on 1/17/1945

Immediate cause of death	Duration
Congestive Heart Failure	1 hr.
Due to Hypertensive Heart Disease	
Due to —	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. Corbin, Jr. M.D.
Address 806 Lexington Bldg. Date signed 1/17/45

VS 150

G21863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G21863

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 E. Preston St
(c) Hospital or institution:

9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey J. Dickinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Elizabeth May

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27 1876

8. AGE: Years 68 | Months 6 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business Samuel I Dell Co

FATHER
12. Name James Dickinson
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Margaret Unknown
15. Birthplace

16 (a) Informant Francis J Dickinson
(b) Address 914 E Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) JAN 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/17 1945 at 7-45 A M

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McMullen M.D. Medical Examiner.
Date signed 1/19/45

VS 151

G24854 G24854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 13 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 N. Patterson Park ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Betty Buskey (Elizabeth)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 | 17 | 45

8. AGE: Years	Months	Days	If less than one day
			1 2 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Dr. Robert Bruce Buckey
13. Birthplace Forest City, Missouri

MOTHER
14. Maiden Name Ruth Allen Moorehouse
15. Birthplace Baltimore, Md.

16 (a) Informant Beth Allen Buckey
(b) Address 1317 N. Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 - 19 - 45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Ave.

18 (a) Funeral director John F. Malley Funeral Home
(b) Address 2434 E. Pratt St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JAN 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 18 - 45 1945, at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/17 1945 to 1/18 1945 and that I last saw h[illegible] alive on 1/18 1945

Immediate cause of death: Congenital Atelectasis — Duration 12½ hrs.
Due to: Prematurity
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. F. L. Stuckert M. D.
Address Bon Secours Hosp. Date signed 1/18/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L. Rose G2483 ✓ G2483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161C

Registered No. _____

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address _____
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 4
(e) Length of stay in Baltimore (yrs., mos., or days) _____

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County _____
(c) City or town Baltimore - 13,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 N. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME Baby Buckey (Susan Virginia)

3 (b) If veteran, name war _____ **3 (c) Social Security Account No.** _____

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife _____
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 1/17/45

8. AGE: Years	Months	Days	If less than one day
			4 hr. 15 min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation _____
11. Industry or business _____

FATHER
12. Name Dr. Robert Bruce Buckey
13. Birthplace Kansas City Missouri

MOTHER
14. Maiden Name Beth Allan Moessbauer
15. Birthplace Baltimore Maryland

16 (a) Informant Beth Allen Buckey
(b) Address 1317 N Patterson Pk Ave

17 (a) Burial (b) Date thereof 1-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Road

18 (a) Funeral director John J Malley Inc
(b) Address 2435 E Oliver St

19 (a) 1-19-45 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-18-45 19___, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/17 1945, to 1/18 1945, and that I last saw h[illegible] alive on 1/18 1945.

	Duration
Immediate cause of death Secondary anemia	2 hrs.
Due to Umbilical Hemorrhage	4 hrs.
Due to _____	
Other Conditions _____	

(Include pregnancy within 3 months of death)
Date of operation _____
Major findings of operation: _____
of autopsy: _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)
(e) Means of injury _____

23. Signature Richard C. Hayden M. D.
Address Bon Secours Hosp Date signed 1/18/45

VS 3

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT X V G24856

CERTIFICATE OF DEATH 157 M

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 33rd & Calvert Sts.
(b) Street address ~~Univ. of Maryland Hosp.~~
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr 8mos
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County ?
(c) City or town Stewartstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Franklin Polaris Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1942

8. AGE: Years	Months	Days	If less than one day
2	8	15	hr. min.

9. Birthplace Stewartstown, Penna.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Solaye George Miller
13. Birthplace Penn.

MOTHER
14. Maiden Name Myrtle E. Sechrist
15. Birthplace Penn.

16 (a) Informant Mrs. Myrtle Miller
(b) Address Stewartstown, Pa.

17 (a) Removal (b) Date thereof January 19, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location New Freedom, Pa.

18 (a) Funeral director J. Jacob Harlan
(b) Address New Freedom, Pa.

19 JAN 19 1945 (b) Hunter for Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15 1945 at 12:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1943 to Jan 15 1945, and that I last saw h.. alive on Jan 15 1945

Immediate cause of death	Duration
Cardiac Insufficiency	
Failure.	
Due to Pulmonary edema	
Due to ascites	
Other Conditions Stenosis of Bile Ducts Biliary Cirrhosis	

(Include pregnancy within 3 months of death)

Date of operation June 23, 1943.

Major findings of operation: Stenosis of Bile Ducts & Distructive Biliary Cirrhosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Fred Hawkins, Jr. M. D.
Address Union Memorial Hosp. Date signed 1-15-45

G24857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G24857

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 245 S. CHAPEL ST.
(c) Hospital or institution: 2-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 245 S. CHAPEL ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: PATRICK STAPLETON

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOWER

6 (b) Name of husband or wife: MARGARET STAPLETON
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 31 1884

8. AGE: Years 60 | Months 9 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER
12. Name MATTHEW STAPLETON
13. Birthplace IRELAND

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace IRELAND

16 (a) Informant ANN STAPLETON (DAUGHTER)
(b) Address 245 S. CHAPEL ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 20/45 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Ziler INC.
(b) Address 403 S. WOLFE ST.

19 (a) JAN 19 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

AM.

20. DATE OF DEATH JAN. 18 1945, at 9/30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943, to Jan 18 1945, and that I last saw h[illegible] alive on 1-18 1945.

Immediate cause of death: ARTERIOSCLEROSIS — Duration 8 Yrs.
Due to CHR. INTERSTITIAL NEPH — 6 mo.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James J. Kavanagh M.D. M. D.
Address 3578 W. Fredrick St. Date signed 1-18-45

G24858 ✓ G24858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 33 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 934 N. Fayette
(c) Hospital or institution: 18

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town, write RURAL and give town)
(d) Street No. 934 N. Fayette
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles P. Parker ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C.

6 (a) Single, married, ~~widowed, or~~ divorced. M

6 (b) Name of ~~husband~~ or wife Ida. A. Parker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16. 1879

8. AGE: Years 65 | Months 7 | Days | If less than one day hr. min.

9. Birthplace Nash. N.C.
(Town, county and state)

10. Usual Occupation Ironworker

11. Industry or business

FATHER
12. Name Charles P. Parker
13. Birthplace Nash. N.C.

MOTHER
14. Maiden name Sarah F. Williams
15. Birthplace Nash. N.C.

16 (a) Informant Ida. A. Parker
(b) Address 934. N. Fayette

17 (a) Burial (b) Date thereof Jan 20-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Lane & St. Chase & Son
(b) Address 636. N. Gilmor St

19 (a) JAN 19 1945 Huntington Williams M.D.
Registrar

VS 166

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16/45 19 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/12/45 to 1/16/45 and that I last saw h alive on 1/16/45 at 10:45 A.M.

Immediate cause of death Pneumonia

Due to

Due to

Other Conditions Senile Psychosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature

Address 934 N. Fayette Date 1/17/45 M.D.

X

Please write in ink, preferably black, and be careful that everything you write is correct and legible. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24859 ✓ G24859 Registered No. 106a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3605 Belvedere Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3605 Belvedere Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Patrick Ryan,

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1875

8. AGE: Years	Months	Days	If less than one day
69	1	10	hr. min.

9. Birthplace Baltimore City. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Balto. City.

FATHER
12. Name William Ryan,
13. Birthplace Ireland,

MOTHER
14. Maiden Name Margaret Howard,
15. Birthplace Scotland,

16 (a) Informant Miss Margaret Ryan,
(b) Address 3605 Belvedere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/45 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cem.
Location Baltimore City,

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) JAN 19 1945 (Date received by Registrar) Huntingtown Prince Geo. Co. Md. Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Jan. 18, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 44 to Jan. 18 1945 and that I last saw h[im] alive on Jan. 12 1945

Immediate cause of death	Duration
pulmonary edema	1/12/45
Due to acute bronchitis and secondary streptococcus	1/18/45 almost a month
Due to septicemia	
Other Conditions ecthyma	12/1/4

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H M Robinson M. D.
Address 106 E. Chase St. Date signed

X

G248.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G248.0

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital D.O.A
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 8

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1137 N. Milton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward C Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Eva Schmidt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14 1885

8. AGE: Years 59 Months 8 Days 3 If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Highway Dept

11. Industry or business Balto City

FATHER
12. Name William Schmidt
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Elizabeth Haans
15. Birthplace Germany

16 (a) Informant Mrs Eva Schmidt
(b) Address 1137 N. Milton Ave

17 (a) Burial (b) Date thereof 1-20-45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Md Ave

18 (a) Funeral director John C Miller Inc
(b) Address 2405 E. Oliver St

19 (a) JAN 19 1945 (b) (Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/17/ 1945 at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Charles L. Gaberman M.D. Medical Examiner.
Date signed 1/17/45

G24871 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G24871

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 W Fayette St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Paul Augusta Rampley

If U. S. Veteran specify WAR

(a) Residence: No. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Maude Rampley

6. DATE OF BIRTH (month, day, year) Nov 25 - 1900

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	1	23	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Hd Co md

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Pylesville Md Hd Co

FATHER

13. NAME Philip H Rampley

14. BIRTHPLACE (city or town) (State or country) Pylesville md

MOTHER

15. MAIDEN NAME Lilly Streett

16. BIRTHPLACE (city or town) (State or country) Pylesville md

17. INFORMANT (Address)

18. BURIAL, CREMATION, OR REMOVAL Place Highland Date 19 Md

19. UNDERTAKER Howard Webb (Address) Forest Grove Pa

JAN 19 1945 Registrar. Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan 18, 1945

22. I HEREBY CERTIFY, That I attended deceased from Jan, 1945, to Jan 15, 1945

I last saw him alive on Jan 16th, 1945 Death is said to have occurred on the date stated above, at 6 A.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Cardiac Dilitation	1 hr
Other contributory causes of importance: Cerebro Vascular disease	2 years

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) J Harry Glassman M.D.

(Address) 2608 Greenmount Ave

VS 2

GIVE CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE of OCCUPATION is very important. See instructions on back of certificate.

G2487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

Registered No. G2487

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1720 E. Pratt St
(c) Hospital or institution: 2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 1720 E Pratt St
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian E Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frank A Smith
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 2/5/1888

8. AGE: Years 56 | Months 11 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Wm Bowling
13. Birthplace Balto

MOTHER
14. Maiden Name Elizabeth Snow
15. Birthplace Balto

16 (a) Informant Frank A Smith
(b) Address 1720 E Pratt St

17 (a) Burial (b) Date thereof Jan 20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004-8 Orleans St

19 (a) JAN 19 1945 Hunting for Williams
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1945; at 12 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1945 to Jan 17 1945 and that I last saw ... alive on Jan 15 1945.

	Duration
Immediate cause of death: Cerebral Cardio-Respiratory Shock.	gaeds
Due to Malignant Liver	?
Due to Cardio-vascular Decompensation	10 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mark J Douglas
Address 700 E. Pratt St. Date signed 1/18/45 M D

VS 150

G24875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51 B 6245 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2037 Orleans St
(c) Hospital or institution: 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2037 Orleans St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Guember

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lena Guember
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) April 8 1868

8. AGE: Years	Months	Days	If less than one day
76	8	20	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Wholesale Grocer

FATHER
12. Name Leonard Guember
13. Birthplace Germany

MOTHER
14. Maiden Name Berthe Bodmer
15. Birthplace Germany

16 (a) Informant Lena Guember
(b) Address 2037 Orleans St

17 (a) Burial (b) Date thereof Jan 20 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E Orleans St

19 (a) JAN 18 1945 (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 1945, at 6 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1944, to 1/18 1945
and that I last saw him alive on 1/17/ 1945

Immediate cause of death Bronchopneumonia — Duration 2 days
Due to Pathologic Fracture — 5 days
of left humerus
Due to Metastatic Cancer — 1 yr.
Prostate
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Karl Greenman
Address 1712 N Patterson Park Ave Date signed 1/19/45 M. D.

VS 150

C21874

AB-91625

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

C21874 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
Md
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 25 N. Castle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emily Harrison or Emma Lee Harrison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?- 40?

8. AGE: Years	Months	Days	If less than one day
40?	?	?	hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Young
13. Birthplace S.C.

MOTHER
14. Maiden Name Liza Neison
15. Birthplace S.C.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-45 (month) (day) (year)
(c) Cemetery or crematory
Location Wimsboro, S C

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Bank St Cayce

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

VS 150 JAN 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan.-17- 1945 at 1.05A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16- 1945 to 1-17- 1945, and that I last saw her alive on 1-17- 1945.

Immediate cause of death cerebral accident (thrombosis) — Duration 3-4 hrs.

Due to

Due to

Other Conditions hypertensive cardiovascular disease; arteriosclerosis (Include pregnancy within 3 months of death)

Date of operation; myocardial degeneration

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Purvis M. D.
Address City Hosp. Date signed 1/18/45

G24875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G24875 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1406 Allan St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Harper

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-18-44

8. AGE: Years | Months 2 mos | Days 26 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Harper
13. Birthplace Tenn

MOTHER
14. Maiden Name Easie Sinkley
15. Birthplace Va

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Ebenezer Wilson
(b) Address 1000 Blankenship ave

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 19 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15-1945 at 10:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-14 1945 to 1-15 1945 and that I last saw h alive on 1-15 1945

Immediate cause of death atelectasis massive — Duration 3 days

Due to pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Kay M.D.
Address J H H Date signed 1-19-45

G21876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832 G21876 Registered No.

JO #20881

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 719 Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathaniel Gaskin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July ?, 1881

8. AGE: Years	Months	Days	If less than one day
63	6	?	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Thomas
13. Birthplace Virginia

MOTHER
14. Maiden Name Lucinda ?
15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 1-20-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Bridgeley Ave

19 (a) JAN 20 1945 (b)
(Date rec'd by registrar) Hunting, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11, 1945, at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28, 1944, to Jan. 11, 1945, and that I last saw him alive on Jan. 11, 1945.

Immediate cause of death	Duration
(a) Bronchopneumonia	
Due to (b) Cerebral Thrombosis	
Due to (c)	
Other Conditions Embolism of one of Cerebral arteries, emphysema	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: same as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Kenneth Smith
Address Balt. City Hosp. Date signed 1/16/45
M.D.

G2187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G2187

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age in years, months, days, hours, minutes. Cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4313 Penhurst Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miller, Bessie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Wm Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wolf Mayer
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah -
15. Birthplace Russia

16 (a) Informant Miss Ethel Miller
(b) Address 4313 Penhurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Jos Levin Bro
(b) Address 1439 E. Balto. St

19 (a) JAN 19 1945 (Date received by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-18 1945, at 1 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11 1944, to 1-18 1945, and that I last saw h[illegible] alive on 1-18 1945.

Immediate cause of death Cardio-Respiratory failure — Duration

Due to Coronary Thrombosis

Due to Hypertensive and Arteriosclerotic heart dis

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Abstract

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jerome N. Harkavy M. D.
Address Sinai Hospital Date signed 1-18-45

93D

G24878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24878 Registered No. 157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 Shirley ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gerald Spivak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-19-45 1941

8. AGE: Years 4 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Sam Spivak
13. Birthplace Russia

MOTHER
14. Maiden Name Eve Bernstine
15. Birthplace Russia

16 (a) Informant Meade JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Y.M.A.R. Assn
Location Windsor Mill Rd.

18 (a) Funeral director Joseph Levin Inc
(b) Address 1439 E. Balto. St

19 (a) (Date rec'd by registrar) JAN 19 1945 (b) Registrar

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-18 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30 1944 to 1-18 1945, and that I last saw h~~im~~ alive on 1-18 1945.

Immediate cause of death: Respiratory failure — Duration: about 20 days

Due to: meningitis — strep ? alpha

Due to:

Other Conditions: Tetralogy of Fallot

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Brimingham M. D.
Address J H H Date signed 1-18-45

Huntington Williams, M.D.

X

G21879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

G21852 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St & Rutland Ave

(c) Hospital or institution:

Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 2814 Woodwork Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Anna Dolgen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: David Dolgen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Sidney –

13. Birthplace Russia

MOTHER 14. Maiden Name Sarah –

15. Birthplace Russia

16 (a) Informant Mrs. Dolgen

(b) Address 2814 Woodwork Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-45 (month) (day) (year)

(c) Cemetery or crematory United Hebrew Cem:

Location Wash. Blvd

18 (a) Funeral director Jacob Levin & Sons

(b) Address 1431 E. Balto. St

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/18 1945 at 2.P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1944 to 1/18 1945 and that I last saw her alive on 1/18 1945

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Hypertension

Due to:

Other Conditions: Resection 2 Bowel for Ca. of Splenic Flexure

(Include pregnancy within 3 months of death)

Date of operation 1944

Major findings of operation: Ca of Splenic Flexure

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Philip Sherman M. D.

Address Date signed

VS 124

G24850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G24850

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2009 E. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 E. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Crowetz

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Fannie —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1880
8. AGE: Years 65 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Ret.
11. Industry or business

FATHER
12. Name Maurice —
13. Birthplace Russia

MOTHER
14. Maiden Name Myllie —
15. Birthplace Russia

16 (a) Informant Sol Crowetz (Son)
(b) Address 1943 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-45 (month) (day) (year)
(c) Cemetery or crematory Russdale
Location

18 (a) Funeral director Jos Perlin & Son
(b) Address 1439 E. Balto St

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-18- 1945, at 10 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1 1932, to Jan 18 1945, and that I last saw h[illegible] alive on Jan 18 1945.

Immediate cause of death: acute cardiac dilation — Duration

Due to: acute coronary infarct

Due to: acute tuberculosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. C. Feldman M. D.
Address 1440 E Balto St Date signed 1/19/45

G2488 Watts

BALTIMORE CITY HEALTH DEPARTMENT ✓ G2488

CERTIFICATE OF DEATH 107

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703½ W. Saratoga St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 703½ W. Saratoga St (If rural give location)
(e) Citizen of foreign country? no (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Joyce Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 9-14-44

8. AGE: Years | Months 4 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Lee
13. Birthplace Md

MOTHER 14. Maiden Name Viola Jenkins
15. Birthplace Md

16 (a) Informant Viola Lee
(b) Address 703½ W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 20 45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna Ave

19 (a) [illegible] (b) [illegible]

JAN 19 1945 Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1945; at 10:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1945 to Jan 18 1945, and that I last saw him alive on Jan 18 1945.

	Duration
Immediate cause of death Bronchial pneumonia	2 weeks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W H. Watts M. D.
Address 575 Arlington Ave Date signed 1/19/45

X

G21882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No. G21882

Correct age is supremely important. If unknown, please write the nearest possible. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 N. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Jones

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1922

8. AGE: Years	Months	Days	If less than one day
23 22			hr. min.

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Robt. Jones.
13. Birthplace Va

MOTHER
14. Maiden Name Sarah Jone
15. Birthplace Va

16 (a) Informant Sarah Jones
(b) Address 105 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Byard Alley

19 (a) Huntington Williams (b) M.E.
(Date rec'd by registrar) JAN 19 1945 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-17- 1945, at 2.15 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Severed Subclavian Artery

Due to Stab wounds

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-17- at 1.30 A M.
(b) Where did injury occur? 106 N. Caroline Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public (Tavern) While at work? No
(d) Means of injury Stab Instrument

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 1-17-45

G24883 147-61-0326

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

169 Registered No. G24883

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 3603 Reed ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Francis A. Bradford

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.: R. R. Ret. 147-01-0326

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife: Dorothy E. Bradford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 5, 1896

8. AGE: Years	Months	Days	If less than one day
48	10	12	hr. min.

9. Birthplace: Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation: Fireman
11. Industry or business: B. & O. R. R.

FATHER
12. Name: Albert Bradford
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Eliza White
15. Birthplace: Md.

16. (a) Informant: Mrs. Dorothy E. Bradford
(b) Address: 3603 Reed St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/45 (month) (day) (year)
(c) Cemetery or crematory: Balto. National Cem.
Location: Baltimore, Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto. Md.

19 (a) (b) Huntington Williams Registrar

JAN 19 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1945 at 8:30 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Crushed base of skull. amputation of right leg, traumatic

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Jan 12 1945 7:30 A.M.
(b) Where did injury occur? Buck ST. 21-2
(c) Did injury occur at home, on farm, industrial place, in public place? B & O. R. R. While at work? Yes
(d) Means of injury: Crushed by train

23. Signature: Robert Lee Graham M.D. Medical Examiner.
Date signed: Jan. 17 1945

G24834 ✓ G24834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Richwood & Greene
(b) Street address ~~730 E. 35th St~~
(c) Hospital or institution: University Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore 3
(c) City or town Baltimore - 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 730 E. 35th St.
(If rural give location)
(e) Citizen of foreign country? not (Yes or No)
If yes, name country .....

3 (a) FULL NAME John W. Reich

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary E. Reich
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 1, 1874

8. AGE: Years	Months	Days	If less than one day
70	6	17	..... hr. ..... min.

9. Birthplace Frederick, Md.
(Town, county, and state)
10. Usual Occupation Interior Decorator
11. Industry or business .....

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Mary E. Reich
(b) Address 730 E. 35th St.

17 (a) Burial (b) Date thereof 1/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. OLIVET CEM.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 19 1945 (b) .....
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1945, at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28 1944 to 1-17, 1945 and that I last saw h.i.m. alive on 1-12 1945

Immediate cause of death Exhaustion, asphyxia.
Due to Pneumonia and Cardiac failure
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)

Duration
22 days
over

Date of operation none
Major findings of operation: none
of autopsy Pneumonia R & Lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....
23. Signature Donald T. Gleason M. D.
Address University Hospital Date signed 1-18-45

Huntington Williams M.D.

885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. C21885

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1833 Penna Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - 17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 Penna Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Winston Flood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	A. A.	widow

6 (b) Name of husband or wife Alice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
68 66	—		hr. min.

9. Birthplace Forest, Va. Bedford Co
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Winston Flood
13. Birthplace Va

MOTHER
14. Maiden Name Alice
15. Birthplace Va

16 (a) Informant Mrs. Nellie Palmer (niece)
(b) Address 1837 Penna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Kelso
(b) Address 1303 Pressman

19 JAN 19 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/17 1945, at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1945 to 1/17 1945, and that I last saw him alive on 1/17 1945

Immediate cause of death	Duration
Ch Myocarditis	1 mo
Due to Chr. nephritis	1 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Casey C. Johnson M. D.
Address 1801 Penna Ave Date signed 1/19/45

G21886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G21886

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-0-A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 Baker Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME alfred anderson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Buchanan Va.
(Town, county, and state)

10. Usual Occupation Busman

11. Industry or business

FATHER
12. Name unobtainable
13. Birthplace Va

MOTHER
14. Maiden Name unobtainable
15. Birthplace Va

16 (a) Informant Sophie Allen
(b) Address 1524 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-45 (month) (day) (year)
(c) Cemetery or crematory National Cem
Location Baltimore Md.

18 (a) Funeral director Wes. G. Nelson
(b) Address 1313 Pressstman St

19 (a) JAN 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15-1945, at 10-15 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Chronic Pulmonary Tuberculosis

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 1-16-45

Please write plainly in ink. Physicians: please write the causes of death clearly and legibly.

G24837 ✓ G24837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 Milliman st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County ..... S
(c) City or town 1511 Milliman St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. .....
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mary Bragg Burke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colored	Married

6 (b) Name of husband or wife William H. Burke
6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) 12, 11, 1870

8. AGE: Years	Months	Days	If less than one day
74	1	5	..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name Amy Eliza Bragg
15. Birthplace Baltimore, Md

16 (a) Informant William H. Burke
(b) Address 1511 Milliman st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn A.A. Co. Md.

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 E. Jefferson St

19 (a) ..... (b) Huntington Williams, M.D. Registrar
Date received JAN 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-16-45 at 12 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 44 to 1/16 1945
and that I last saw her alive on 1/16 1945

Principal cause of death: Cardiac failure Endocarditis
Due to: Indefinite
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

Duration: 2 wks.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....
23. Signature Isaac R. Blake M.D.
Address 1327 N. Central Ave Date signed 1/18/45

VS 150

G24838 G24838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83Q

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital-Dis
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 913 Tyson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Bennett

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 50 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace W

MOTHER
14. Maiden Name Unknown
15. Birthplace W

16 (a) Informant Mr. John Bennett
(b) Address 913 Tyson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JAN 19 1945 (Registered by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/16 1945, at 8:30 A. M

21. I certify that I took charge of the remains described above, held an Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature [illegible] M.D. Medical Examiner.
Date signed 1/16/45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G24886 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St
(c) Hospital or institution: Univ Hosp 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 ½ hr.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 738 W. Franklin St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Lee Fisher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years 33 yrs | Months | Days | If less than one day hr. min.

9. Birthplace Kinston N.C (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ? Unknown
13. Birthplace

MOTHER
14. Maiden Name Ida King
15. Birthplace N. C.

16 (a) Informant Mr. Lee Fisher
(b) Address 738 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-45 (month) (day) (year)

(c) Cemetery or crematory
Location Kinston, N. C.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) JAN 19 1945 (b) Huntington Williams M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 1-16 1945, at 2 08/A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8½ a 1-15 1945 to 2 08 p.m. 1-16 1945. and that I last saw her alive on 1-16 1945.

Immediate cause of death	Duration
Coma	
Due to Diabetes Mellitus	
Due to	
Other Conditions Resp. Failure.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done here

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. Faulkner M. D.
Address Univ Hosp Date signed 1-18-45

X

G24890 ✓ G24890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 16

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address ~~1328~~ Harford Rd & Herring Run

(c) Hospital or institution: Sydenham Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 14 yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or Town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1328 Binder Ct. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country —

3 (a) FULL NAME Eliza Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Negro	Married

6 (b) Name of husband or wife Joseph Brown

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) ? 1915

8. AGE: Years	Months	Days	If less than one day
30 29	?	?	hr. min.

9. Birthplace Bethune, S.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Kirk

13. Birthplace Bethune, S.C.

MOTHER 14. Maiden Name Jamie ?

15. Birthplace Bethune, S.C.

16 (a) Informant Husband (Joseph Brown)

(b) Address 1328 Binder Ct.

17 (a) removal (Burial, cremation, or removal) (b) Date thereof Jan. 19, 1945 (month) (day) (year)

(c) Cemetery or crematory .....

Location Mc Bee, South Carolina

18 (a) Funeral director A. Raymond Harford

(b) Address 9 E. Lanvale St.

19 (a) ..... (b) .....

(Date rec'd by registrar) (Registrar)

JAN 19 1945 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-13 1945, at 11:52 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11 1945 to 1-13 1945.

and that I last saw h.E.R alive on 1-13 1945

Immediate cause of death Respiratory failure — Duration .....

Due to Tuberculous meningitis — 1 week

Due to Tubercle bacillus — .....

Other Conditions Pott's disease — .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature Margaret N.D. Saville M. D.

Address Sydenham Hosp Date signed 1-19

X

G24891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G24891

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 414 Forrest St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 Forrest St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Cefalu

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~xxxxx~~ John Cefalu
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 5 1887

8. AGE: Years	Months	Days	If less than one day
57	5	12	hr. min.

9. Birthplace Marina Di Tusa -Messina-Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Pietro Santo Palmisano
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta Cefalu
15. Birthplace Italy

16 (a) Informant John Cefalu (Husband)
(b) Address 414 Forrest St.

17 (a) Burial (b) Date thereof Jan 20 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Rd. Baltimore Md

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

19 (a) JAN 19 1945 (Huntington Williams, M.D.)
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17 1945, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 17 1945, to Jan. 17, 1945, and that I last saw her alive on Jan. 17 1945

Immediate cause of death	Duration
Coronary Thrombosis	1 hour
Due to Coronary artery disease.	5 days.
Due to Hypertensive Cardio Vascular disease.	5 days.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sa Zimmerman M. D.
Address Medical Arts Bldg Date signed 1/18/45

G24892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55C

G24892 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2218 Gough St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernice Morris (Bronislowa Adelinowska)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, Married, widowed or divorced Married Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) 12-14-90 ~~12-14-98~~

8. AGE: Years 54 ~~55~~ Months 1 Days 4 If less than one day hr. min.

9. Birthplace Poland.
(Town, county, and state)

10. Usual Occupation House Wife.

11. Industry or business

FATHER 12. Name Joseph Oparowski

13. Birthplace Poland.

MOTHER 14. Maiden Name Marie Crawhorn

15. Birthplace Poland.

16 (a) Informant records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 22/45 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Baltimore

18 (a) Funeral director Fred W Ozmuzenski

(b) Address 1930 Eastern Ave

19 (a) JAN 19 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-18 1945 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30 1944 to 1-18 1945.
and that I last saw her alive on 1-18 1945.

Immediate cause of death ASPHYXIA — Duration

Due to Carcinoma of thyroid

Due to

Other Conditions

(Include pregnancy within three months of death)

Date of operation 1-3-45

Major findings of operation: Carc. of thyroid

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Handelman MD

Address 1111 Date signed 1-18-45

(over)

G24893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G24893

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use no abbreviations. Give exact date of birth and correct age if possible. If not possible, write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4201 Massachusetts Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4201 Massachusetts Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John B. Reeside

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Florence M. Reeside

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 19, 1861

8. AGE: Years 83 | Months 1 | Days 30 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Groceryman

11. Industry or business

FATHER
12. Name James Reeside
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Lydia A. Burgess
15. Birthplace Baltimore, Maryland

16 (a) Informant F. Thelma Reeside
(b) Address 4201 Massachusetts Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 20, 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director Mr. & Mrs. John W. Teufel &
(b) Address 801 W. Fayette Street

19 (a) JAN 19 1945 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18, 1945, at 12:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7, 1943, to Jan. 18, 1945, and that I last saw him alive on Jan. 17, 1945.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Arteriosclerotic Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
Sons
(e) Means of injury

23. Signature Geo. H. Kemp M.D.
Address 3030 Edmondson Ave. Date signed 1/19/45

X

G24894 ✓ G24894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 15 7E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1011 Rectory Lane
(c) Hospital or institution: L 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 Rectory Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Beverly Jean Graf

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27-1944

8. AGE: Years —; Months 9; Days 19; If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Norman Algire Graf
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Louise O'Brien
15. Birthplace Maryland

16 (a) Informant Mrs. Charles H. Graf
(b) Address 1014 N. 38th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 20-1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Royal Hampden
Location Baltimore Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) JAN 20 1945 (Date rec'd by registrar) Hunter A. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 1945, at 5-45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/24/44 19 to 1/16/45 19, and that I last saw h[illegible] alive on 1/16/45 19

Immediate cause of death: Congenital Heart — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A. Bacon
Address 100 E 20th St Date signed 1/17/45 (M. D.)

VS 150

G24895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24895 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wagner Ave & Dukeland St
(c) Hospital or institution: West Balto. Gen. Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) Day Sick
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3831 Roland Ave #11 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wesley Coleman Thorpe

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-07-1532

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Sarah Elizabeth Thorpe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4-1868

8. AGE: Years 76 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace South Lebanon Ohio (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business Retired 4 years

FATHER 12. Name William Thorpe

13. Birthplace Unknown

MOTHER 14. Maiden Name Elizabeth Bonnie

15. Birthplace Unknown

16 (a) Informant Frank N. Thorpe

(b) Address 3831 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 20-1945 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore, Maryland

18 (a) Funeral director Burgan Funeral Home

(b) Address 3621 Falls Road

JAN 19 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/17 1945, at 5:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/12 1945 to 1/17 1945, and that I last saw him alive on 1/17 1945.

Immediate cause of death Myocardial failure Asst. C.V.D. — Duration

Due to Cardiac enlargement Amurism [illegible]

Due to Decompensation advanced

Other Conditions Asystemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Taylor

Address W 6 E 6 N Date signed 1/17/45

G24896

BALTIMORE CITY HEALTH DEPARTMENT ✓G24896

CERTIFICATE OF DEATH 181

Registered No. 118152

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4105 Maine Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie E. Treide

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife George F. Treide

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 16, 1885

8. AGE: Years	Months	Days	If less than one day
59	3	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Lange
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Hetz
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Edward H. Lange
(b) Address 3801 Hillsdale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 20, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Wilbur Lamoreaux
(b) Address 4510 Liberty Heights Ave.

19 (a) Huntington Williams M.D. (Signature of registrar)

JAN 19 1945
Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1945 at 925 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/14 1944 to 1/18 1945 and that I last saw h e alive on 1/18/45 1945.

Immediate cause of death Cardiac failure — Duration

Due to Uremia

Due to

Other Conditions Severe HBP. Severe arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 28/2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence December 15, 1944 M
(c) Where did injury occur? 4105 Maine Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At home (Specify type of place) While at work? No
(e) Means of injury Spilled carbolic acid on left foot.

23. Signature Hu Stair M.D. Elsa M.D.

Address St. Agnes Hospital Date signed 1/20/45

Approved: Chester J. Lubinski M.D. per Robert Lee Graham M.D.

G24897

AB-91584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G24897 Registered No.

Every item of information should be carefully answered; write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 613 E. Biddle St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William B. Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No. Yes

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-23-1894

8. AGE: Years 50 Months 3 Days 26 25 If less than one day hr. min.

9. Birthplace Baltimore-Md. (Town, county, and state)

10. Usual Occupation Driver-Yellow Cab Co.

11. Industry or business

FATHER 12. Name William Murphy

FATHER 13. Birthplace Baltimore-Md.

MOTHER 14. Maiden Name Margaret Mellon

MOTHER 15. Birthplace Baltimore-Md.

16 (a) Informant Baltimore City Hospitals(Record

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date there Jan 22 1945 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location

18 (a) Funeral director Chas J. Evans Son Inc

(b) Address 118 W. Mt. Royal Ave

19 (Signature and address of local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18- 1945, at 5.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13- 1945 to 1-18 1945, and that I last saw him alive on 1-18- 1945

Immediate cause of death

	Duration
Pulmonary tuberculosis	6 mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Harold Rillon M. D.

Address Balto City Hosp. Date signed 1/18/45

VS 180

JAN 19 1945

G21898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G21898 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3503 N. Charles St.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3503 N Charles St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Susan Cornelia von Riesen

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Single

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 15 1858

8. AGE: Years 86 | Months 10 | Days 3 | If less than one day: hr. min.

9. Birthplace Winchester - Va (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Henry von Riesen
13. Birthplace Winchester - Va.

MOTHER
14. Maiden Name Frances Brown
15. Birthplace Winchester - Va.

16 (a) Informant Mrs James Feaney (aide)
(b) Address 3503 N Charles St -

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof Jan - 20 - 45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Stewart Mortuary Co.
(b) Address 1528 W Mont Ave.

19 (a) JAN 19 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1945 at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1937 to Jan 18 1945, and that I last saw her alive on Jan 17 1945

Immediate cause of death: Myocarditis — Duration: 1 Month
Due to: Arterio - Sclerosis — Duration: Gradual
Due to: —
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature W H Brady M.D.
Address 140 S Paca St Date signed 1/19/45

Huntington Williams, M.D.

VS 150

G24899 BALTIMORE CITY HEALTH DEPARTMENT G24893
Registered No.

CERTIFICATE OF DEATH 93D

Every item of information should be carefully supplied. Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2129-N-Charles
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2129-N-Charles St
(If rural, give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Brady Sadtler

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: Single
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr-21-1859

8. AGE: Years 85 | Months 8 | Days 28 | If less than one day: hr. min.

9. Birthplace: Balto Co. Md (Town, county, and state)
10. Usual Occupation: none
11. Industry or business:

FATHER
12. Name C. Columbus Sadtler
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Brady
15. Birthplace Baltimore

16 (a) Informant Mrs C. Sadtler
(b) Address 2129-N-Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore

18 (a) Funeral director Stewart Mowen Co.
(b) Address 1600 Eutaw Place

19 (a) JAN 19 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 1945, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1933 to Jan 19 1945; and that I last saw her alive on Jan 16 1945.

Immediate cause of death: Myocarditis Arteriosclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: Unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W H Brady M.D.
Address 1402 Lafayette Date signed 1/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write

VS 150

G24900 HEALTH DEPARTMENT—CITY OF BALTIMORE G24900

53-3570 V

CERTIFICATE OF DEATH 1379

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Alexander Jordan St., 21 Exeter Ward) 5

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Alexander Jordan

If U. S. Veteran specify WAR

(a) Residence: No. 21 N. Exeter St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	C	S

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Jan. 13, 1945

7. AGE Years	Months	Days	If LESS than 1 day hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. X

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. X

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore - N. Exeter Balto - Md.

FATHER

13. NAME John Jordan

14. BIRTHPLACE (city or town) (State or country) Burga N.C.

MOTHER

15. MAIDEN NAME Mary Young

16. BIRTHPLACE (city or town) (State or country) Wilson Wilson N.C.

17. INFORMANT Mary Jordan

(Address) 21 N. Exeter

18. BURIAL, CREMATION, OR REMOVAL

Place Date 19

19. UNDERTAKER UNIVERSITY MEDICAL SCHOOL JAN 18 1945

(Address) JAN 19 1945 Commissioner of Health

Registrar.

JAN 19 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 1-14-, 1945

22. I HEREBY CERTIFY, That I attended deceased from Jany 13 1945 to 19

I last saw h alive on Jan 13 '45, 1945. Death is said to have occurred on the date stated above, at 6 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Prematurity	

Other contributory causes of importance:

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

22. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) [illegible] M. D.

(Address) 1443 E. Eager St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact OCCUPATION is very important. See instructions on back of certificate.

2456

G24901 ✓ G24901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No.....

Please answer all questions clearly and legibly. Physicians: please write the causes of death clearly and legibly. Correct age is especially important. Informants: please read carefully before signing. JW

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 Watson St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Ada Pitts

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
45			..... hr. ..... min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....
FATHER 12. Name.....
13. Birthplace.....
MOTHER 14. Maiden Name.....
15. Birthplace.....
16 (a) Informant.....
(b) Address.....
17 (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location UNIVERSITY MEDICAL SCHOOL JAN 18 1945
18 (a) Funeral director Commissioner of Health
(b) Address.....
19 (a) JAN 19 1945 Hartley H. Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-5- 1945 at 9 20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Adeno Carcinoma of Uterus
Due to.....
Other Conditions Peritonitis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Seward E. Miller M.D.
Medical Examiner.
Date signed 1-5-45

VS 151 —61

2455

24902 G24902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 Monumental Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME CLINTON LEIGH Baby Boy Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1944

8. AGE: Years — | Months 5 4 | Days 2 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business —

FATHER
12. Name Samuel Leigh Brown
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rose Nickens
15. Birthplace Fairfax, Virginia

16 (a) Informant Birth Certificate
(b) Address City Health Dept.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JAN 18 1945.

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1945, at 12:15 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Pneu death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobular pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fraker M.D.
Medical Examiner.
Date signed 1-8-45

VS 151

2457 X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G24903 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1817 Henneman Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 Henneman Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ADAM BUSSE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of [redacted] or wife Carrie Komenda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1879

8. AGE: Years	Months	Days	If less than one day
65 yrs.	4	5	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation City Employee
11. Industry or business

FATHER
12. Name Carl Busse
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Winkus
15. Birthplace Germany

16 (a) Informant Mrs. Carrie Busse
(b) Address 1817 Henneman Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/45 (month) (day) (year)
(c) Cemetery or cr[redacted] Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

JAN 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 17, 1945, at 8A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 15, 1945 to JAN. 17 1945, and that I last saw h[redacted] alive on JAN. 16 1945.

Immediate cause of death CEREBRAL HEMORRHAGE — Duration 9 Mo.

Due to Arteriosclerosis —

Due to

Other Conditions Right side paralysis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis F. Klimes M. D.
Address 2623 E. Monument Date signed 1/18/45

G24901 ✓ G24901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83-A Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 632 N. Kenwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 632 N. Kenwood Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME CAROLINE MARY SCHMIDT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: George J. Schmidt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1884

8. AGE: Years 60 yrs. | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Julius Neuschaefer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Schuman
15. Birthplace Baltimore, Md.

16 (a) Informant Rita Cleary (daughter)
(b) Address 632 N. Kenwood Avenue

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 1/22/45 (month) (day) (year)
JAN 19 1945

(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (Date rec'd by registrar) (b) JAN 19 1945 Registrar Huntington Mills M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Januery 18 1945, at 7.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11 1945 to Jan. 18 1945 and that I last saw her alive on Jan. 17. 1945.

Immediate cause of death: Cerebral apoplexy — Duration: 7 days

Due to: Hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. J. Schmidt M. D.

Address 701 N. Kenwood Ave. Date signed 1-19-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No. G24905

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 929 N Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Forame

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/6/45

8. AGE: Years	Months	Days	If less than one day
		12	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Charles Forame
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Mary Welsh
15. Birthplace N. Y.

16 (a) Informant Records
(b) Address Mercy Hospital

17 (a) Burial (b) Date thereof 1/20/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul st

19 (a) JAN 19 1945 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/18/45 19 , at 2:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1PM 1/18 19 45, to 2:20 PM 1/18/45 and that I last saw h[illegible] alive on 1/16 19 45

Immediate cause of death Pneumonia — Duration 1

Due to Atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. F. Holdmann M.D.
Address Mercy Hosp Date signed 1/18/45

G2190 BALTIMORE CITY HEALTH DEPARTMENT G2190
CERTIFICATE OF DEATH 83a
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Belloni Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Elkridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Marcia L Palmer

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wilbourne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23-1876

8. AGE: Years 68 | Months 2 | Days 25 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John Swormstedt
13. Birthplace Havre de Grace Md

MOTHER
14. Maiden Name Marcia Carter
15. Birthplace Havre de Grace Md

16 (a) Informant Mary Moore
(b) Address Elkridge Md

17 (a) Cremation (b) Date thereof 1/20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilbourn & Son
(b) Address 1217 E Pratt St

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 19 45 at 10 3/4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1945 to Jan 18 1945 and that I last saw h alive on Jan 18 1945.

Immediate cause of death: Paralysis
Due to:
Due to: Pulmonary Atelectasis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: 4 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 112 W. 25 Ave Date signed 1-18-45

G24907 G24907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 728 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Blackistone

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Blackistone
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13th 1873

8. AGE: Years	Months	Days	If less than one day
71	6	4	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Special Policeman
11. Industry or business City of Balto.

FATHER
12. Name John Blackistone
13. Birthplace St. Marys Co. Md.

MOTHER
14. Maiden Name Lena Davis
15. Birthplace Annapolis Md.

16 (a) Informant Mary E. Blackistone
(b) Address 728 W. Lexington st.

17 (a) Burial (b) Date thereof 1/20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) JAN 19 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1945, at 6 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 30 P.M. 1/17 1945 to 6 45 P.M. 1/17 1945, and that I last saw him alive on 1/17 1945.

Immediate cause of death: Coronary sclerosis
Due to: Myocardial dilatation
Due to:

Other Conditions: Myocardial fibrosis, chronic passive congestion lungs.
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: Coronary sclerosis, arteriosclerosis

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Wirt Hollis M.D.
Address University Hospital Date signed 1/19/45

G24908 G24908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No.

(PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1434 N. Bond st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1434 N. Bond st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella M. Elliott

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 16th 1871

8. AGE: Years 73 | Months 9 | Days 2 | If less than one day: hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)
10. Usual Occupation: None
11. Industry or business:

FATHER
12. Name (Unknown) Elliott
13. Birthplace "

MOTHER
14. Maiden Name Mary E. (Unknown)
15. Birthplace Md.

16 (a) Informant: Anna M. Barbour
(b) Address: 1434 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/45 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location " Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul st.

19 (a) JAN 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 18th 1945, at 10:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1944, to 1/18 1945, and that I last saw h[illegible] alive on 1/4 1945.

Immediate cause of death: Coronary Thrombosis.
Duration: Sudden
Due to: Hypertension Cardiovascular Disease ?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Inga S. Blum M.D.
Address: 1206 E. Preston Date signed: 1/18/45

Huntington Hill

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT X G24909

CERTIFICATE OF DEATH 82a

G24909 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 - 3 - 14
(e) Length of stay in Baltimore (yrs., mos., or days) 38 - 3 - 14

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Roanoke (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 Stanley Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Robert J. Woodrum

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1877

8. AGE: Years	Months	Days	If less than one day
67	5	15	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Robert W. Woodrum
13. Birthplace Virginia

MOTHER
14. Maiden Name Annie Musgrove
15. Birthplace Virginia

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/19/45 (month) (day) (year)
(c) Cemetery or crematory
Location Roanoke Va

18 (a) Funeral director Nicholson & Tuckner & Sons
(b) Address North & Carey Streets Roanoke Va

19 (a) 1945 (Date rec'd by Registrar) (b) Registrar Wilson

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 1945, at 2:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1934 to Jan 19 1945, and that I last saw him alive on Jan 19 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	3 wks
Due to	
Due to	
Other Conditions Schizophrenia Paranoid type	38 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Samuel P. Gay M. D.
Address 334 Goodwin Ave Date signed

G249 0 BALTIMORE CITY HEALTH DEPARTMENT G249 0

CERTIFICATE OF DEATH 45B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1335 W. 42nd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1335 W. 42nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL BENJAMIN EASTON

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	181-01-1780

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence A. Easton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1876

8. AGE: Years	Months	Days	If less than one day
68	1	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Supt.
11. Industry or business Construction Co.

FATHER
12. Name William T. Easton
13. Birthplace Montgomery Co., Md.

MOTHER
14. Maiden Name Sarah E. Lusby
15. Birthplace Md.

16 (a) Informant Mrs. Florence A. Easton
(b) Address 1335 W. 42nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

JAN 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18, 1945, at 5:25 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1945, to Jan 18 1945, and that I last saw him alive on Jan 18 1945

Immediate cause of death	Duration
Myocarditis	1 week
Thrombosis	
Due to Carcinoma of tongue with	1 yr.
Due to Exhaustion	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation June 1944
Major findings of operation: Carcinoma of tongue and metastasis
of autopsy [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Wm. H. Smith M. D.
Address 3429 Clarinda Ave Date signed Jan 19 1945

Wm. H. Smith

G24911 Heller G24911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town York Pa.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Colonial Hotel.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry C. Heller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Artist
11. Industry or business Artist

FATHER
12. Name Augustus Heller
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Pa.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/22/45 (month) (day) (year)

(c) Cemetery or crematory
Location York, Pa.

18 (a) Funeral director Wm. J. Tichner & Sons
(b) Address York & Pa. Aves. Balt. Md.

19 (a) JAN 19 1945 (Date received by registrar) (b) Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-18 1945, at 10 42 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1945, to 1-18 1945, and that I last saw h alive on 1-18 1945.

Immediate cause of death: Acute Peritonitis
Myocardial Infarction
Due to Arterio + arteriolosclerosis
Due to ? Syphilis

Duration
5-10 days

Other Conditions Hypertensive Cardiovascular Disease
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurie Duckett M. D.
Address Johns Hopkins Hospital Date signed 1/19/45

G24913 BALTIMORE CITY HEALTH DEPARTMENT G24913

CERTIFICATE OF DEATH 1937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 Bloomingdale Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Bloomingdale Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Edward Wood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ wife Audrey Reay Wood
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Nov 17th 1874

8. AGE: Years	Months	Days	If less than one day
65	2	1	hr. min.

9. Birthplace Elizabeth N. C. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Civil Service

FATHER
12. Name Julian E. Wood
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Scott
15. Birthplace Pasquotank Co. N. C.

16 (a) Informant Audrey Reay Wood
(b) Address 1208 Bloomingdale Rd

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/19/45 (month) (day) (year)
(c) Cemetery or crematory Elizabeth City
Location N. C.

18 (a) Funeral director William Cook Inc
(b) Address 217 St Paul St

19 (a) 1/19 1945 (Registrar's signature) (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 1945 at 10 32 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/18 1945 to 1/18 1945 and that I last saw h[illegible] alive on 1/18 1945

Immediate cause of death Coronary Occlusion — Duration 1/18/45

Due to Coronary Atherosclerotic Heart Disease — 1 yr+

Due to

Other Conditions Bronchial Asthma — 10 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. E. Roach, M.D.
Address 3629 Edmondson Date signed 1/19/45 M. D.

G24913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G24913
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the ... the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hosp.
(c) Hospital or institution: Lombard & Green

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 N. Castle St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward K. McKuska

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-1814

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife. None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21st 1889

8. AGE: Years 55 | Months 4. | Days 28 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Nat. Distillery Co.

11. Industry or business Foreman

FATHER
12. Name Frank McKuska
13. Birthplace Maryland.

MOTHER
14. Maiden Name Ella Parker
15. Birthplace Maryland.

16 (a) Informant Mrs James Parker
(b) Address 420 Woodlea Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/45 (month) (day) (year)

(c) Cemetery or crematory Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 420 St. Paul St

19 (a) JAN 20 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-19-45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15-45 19 , to 1-19-45 19 , and that I last saw him alive on 1-19-45 19 .

Immediate cause of death - Septicemia -
Diabetic Coma - Cellulitis
7 left ear
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1-17-45

Major findings of operation: - Cellulitis
7 left ear,

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. W. Mentzer M. D.
Address Univ. Hosp. Date signed 1-19-45

X

G24914

G24914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3814 Ridgecroft Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3814 Ridgecroft Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie M. Borrell

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 1st 1871

8. AGE: Years	Months	Days	If less than one day
73	1	17	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business School Teacher

FATHER
12. Name Pablo M. Borrell
13. Birthplace Cuba

MOTHER
14. Maiden Name Jane Gifford
15. Birthplace Balto. Md.

16 (a) Informant Marie Rasleigh
(b) Address 3313 Ailoa Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1343 St. Paul St.

19 (a) JAN 20 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18th 1945, at 9:25 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Jan 18 1945, and that I last saw h alive on 19

Immediate cause of death Pneumonia

Due to Cardiac Decompensation

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 15 day

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 300 N Bond St Date signed 1945

Registrar

VS 150

G24915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24915 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2026 Cliftwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-5
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2026 Cliftwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johanna W. Vickers

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~or wife~~ Jos. L. Vickers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2nd 1883

8. AGE: Years 62 | Months 0 | Days 10 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation H. D. Home
11. Industry or business

FATHER
12. Name Carl Freter
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Rastaff
15. Birthplace Germany

16 (a) Informant Mrs. J. Freter
(b) Address 2026 Cliftwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/45 (month) (day) (year)
(c) Cemetery or crematory Mouland Mem. Park
Location Balto.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) JAN 20 1945 (Entered by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17 1945 at 3½ P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 24 1944 to Jan 17 1945, and that I last saw h~~er~~ alive on June 7 1945

Immediate cause of death: Cardiac Thrombosis — Duration 1 hr

Due to Senile Dementia — 2 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 18 Randolph
Date signed

G24916

467423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6

Registered No. G24916

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3601 N. Greenspring Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thelma I. Shortt

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Paul E. Shortt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-10-99.

8. AGE: Years 45 | Months 3 | Days 8 | If less than one day hr. min.

9. Birthplace md. (Town, county, and state)

10. Usual Occupation Technician.

11. Industry or business J. H. H.

FATHER
12. Name Charles Unglaub.
13. Birthplace md.

MOTHER
14. Maiden Name Ella E.
15. Birthplace Va.

16 (a) Informant Friend.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial, cremation, or removal (b) Date thereof 1/22/45 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem

Location

18 (a) Funeral director William Lee Sons

(b) Address 1218 Park Ave

JAN 20 1945

Date received by local registrar Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 18 1945, at 1100 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan - 17 1945 to Jan - 18 1945, and that I last saw h[illegible] alive on Jan - 18 1945.

Immediate cause of death	Duration
Respiratory collapse	
Due to Meningococcal Meningitis	2 days
Due to	
Other Conditions none	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Dixon

Address Johns Hopkins Hosp Date signed 1/18/45

VS 150

G24917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G24917 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 31 E. Ostend St

(c) Hospital or institution: 23-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 31 E. Ostend St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret A. Armandt.

3 (b) If veteran, name war no

3 (c) Social Security Account No. no

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Louis Armandt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2. 1862.

8. AGE: Years 83 | Months 0 | Days 16 | If less than one day hr. min.

9. Birthplace Ellicott City Md. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Frederick Schmidt

13. Birthplace Germany.

MOTHER 14. Maiden Name Margaret King

15. Birthplace Balto. Md.

16 (a) Informant Charles albert Jr.

(b) Address 31 E. Ostend St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 22. 1945 (month) (day) (year)

(c) Cemetery or crematory Western

Location City

18 (a) Funeral director John W. Tenfel & Son

(b) Address 801 W. Fayette St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 188 JAN 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18th 1945. at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6/45 19 to Jan. 18/45. and that I last saw her alive on Jan. 18/45.

Immediate cause of death: Pyloric Obstruction possibly cancerous. — Duration: Unknown.

Due to

Due to

Other Conditions: Unknown.

Multiple Sclerosis. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Henry Hands Chaney M. D.

Address 403 Hanover Date signed Jan. 19/45

From 2918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

Registered No. G24913

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: St. Agnes Hospital 2000 E
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2918 Wiekens ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John a. Martin

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Caretaker

11. Industry or business Crystal Beach

FATHER
12. Name Geo. Martin
13. Birthplace Md.

MOTHER
14. Maiden Name Eleanora Richstein
15. Birthplace Pa.

16 (a) Informant Mrs. Edw. J. Kyne
(b) Address 2718 Wilkens Ave

17 (a) Burial (b) Date thereof Jan. 20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2930 Frederick Rd

18 (a) Funeral director Harry H. Mitzel
(b) Address 4101 Edmondson Ave

19 (a) JAN 20 1945 (b) Huntington Williamsburg, Md.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-17- 1945, at 8 05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull.

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-17- at 7.30 P.M.
(b) Where did injury occur? Frederick Rd, nr Mt. Olivet
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no 20-6
(d) Means of injury Pedestrian struck by street car

23. Signature Howard J. Waldeck M.D.
Medical Examiner.
Date signed 1-18-45

G24913 WRIGHT G24913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56E

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland Gen. Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 217 S. Catherine St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3 (a) FULL NAME James Edgar Wright

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Katherine Wright
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1884

8. AGE: Years	Months	Days	If less than one day
60	-	28	..... hr. ..... min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business .....

FATHER
12. Name James Wright
13. Birthplace Ireland

MOTHER
14. Maiden Name Connelly
15. Birthplace Balto., Md.

16 (a) Informant Katherine Wright
(b) Address 217 S. Catherine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 20 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Wright
(b) Address 4101 Edmondson Ave

19 (a) JAN 20 1945 (Date received by registrar) (b) Huntington Williams, Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1945, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 16 1945 to Jan 17 1945, and that I last saw him alive on Jan 17 1945.

Immediate cause of death	Duration
Coronary Thrombosis Myocardial failure	
Due to Infected hematoma & diabetes	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)
Date of operation Jan 17, 1945
Major findings of operations Infected hematoma
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Clifford McCormack M. D.
Address Maryland Gen. Hospt. Date signed 1/17/45

DRENNEN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 6219

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 633 E. 36th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-3
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 633 E 36 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Winfield O. Drennen

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife:
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 31, 1907
8. AGE: Years 37 | Months 2 | Days 16 | If less than one day hr. min.
9. Birthplace Havre de Grace Md (Town, county, and state)
10. Usual Occupation Welder
11. Industry or business Md Dry Docks

FATHER
12. Name Jackson O. Drennen
13. Birthplace Md

MOTHER
14. Maiden Name Charlotte M. Sample
15. Birthplace Pa

16 (a) Informant Mrs Charlotte M. Drennen
(b) Address 633 E. 36th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/45 (month) (day) (year)
(c) Cemetery or crematory Angel Hill
Location Havre de Grace Md

18 (a) Funeral director Harry A. Critzke
(b) Address 410 Edmondson Ave

19 (a) [illegible] 1945 (Date rec'd by Registrar) (b) Huntington Hill Cemetery MD

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 1945, at 10:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 Jan 1945 to 16 Jan 1945, and that I last saw h alive on 16 Jan 1945.

Immediate cause of death: Coronary Thrombosis — Duration 7 Dec

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Z Bruce Hooper, M.D.
Address 3534 Ellerslie Date signed 1/18/45

VS 150

G24921 G24921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 115 C

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Tolbert
(c) Hospital or institution: Franklin Sq Hosp 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Eva Murray

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5 1924

8. AGE: Years	Months	Days	If less than one day
20	8	13	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Joshua Murray
13. Birthplace Md

MOTHER
14. Maiden Name Otail Ann Murray
15. Birthplace Md

16 (a) Informant Otail Murray
(b) Address 1606 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 — 22 — 45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md

18 (a) Funeral director Granger A Hendley
(b) Address 2 W Biddle St

JAN 20 1945

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 — 18 1945, at 11 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17 1945 to 1-18 1945, and that I last saw h[illegible] alive on 1-18 1945.

Immediate cause of death	Duration
Respiratory failure	
while under Intratheacal	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1-18-45
Major findings of operation: Ca
Tentative diagnosis Suicide
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident ?
(b) Date of occurrence 1-18-45 at 11 45 AM
(c) Where did injury occur? FRANKLIN SQUARE HOSPITAL Balto Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? no While at work? 0
(Specify)
Hazard involved
(e) Means of injury
23. Signature J. Carl Myers
Address Franklin Sq Hosp Date signed 1/18/45

For M. J. Submitted by Thomas S. Marsden M.D. X

G24922 — BALTIMORE CITY HEALTH DEPARTMENT — G24922 Registered No.

CERTIFICATE OF DEATH 477

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1413 Reynald Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) 31

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Reynald Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Waclaw Rykowski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Rykowski
6 (c) If widow, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15 1896

8. AGE: Years	Months	Days	If less than one day
48	5	4	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Joseph Rykowski
13. Birthplace Poland

MOTHER
14. Maiden Name Katarzyna Gromczyk
15. Birthplace Poland

16 (a) Informant Mrs. Mary Rykowski
(b) Address 1413 Reynald Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 20 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 20 1945 Huntington Matthews, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 1945 at 11.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945 to Jan 19 1945 and that I last saw deceased alive on Jan 19 1945.

Immediate cause of death	Duration
Carcinoma Rt. Lung	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gerhard Lucas M. D.
Address 1032 Eastern Date signed

G24923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G24923

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1710 Lakeside Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 Lakeside Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph T. Singewald, of G.

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Alverta Irene Singewald
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Nov. 7. 1882

8. AGE: Years 62 | Months 2 | Days 11 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Internal Revenue Agent
11. Industry or business U.S. Goverment

FATHER
12. Name George Singewald,
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Windfelder. Baltimore Md.
15. Birthplace Baltimore Md.

16 (a) Informant Mrs A. Irene Singewald,
(b) Address 1710 Lakeside Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 22 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Ave
Location Baltimore Md.

18 (a) Funeral director Robert S. Little,
(b) Address 2700 Edmondson Av

19 JAN 20 1945 (b) Huntington Williams, M.D. Registrar
(Registered by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15 1945, at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-14- 1945 to 1-15 1945
last saw him alive on 1-13- 1945

Immediate cause of death: Congestive Heart Failure — Duration: 1 day
Due to: Pneumonia — 2 days
Due to:
Other Conditions: over
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. S. Williams Jr. M.D.
Address 1901 E. Fayette St Date signed 1-19-45

VS 180

G24924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. G24924

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hospital 16-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2726 Harlem Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Heinmuller

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-2272

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret Heinmuller

6 (c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.) Oct 10 1876

8. AGE: Years 68 | Months 3 2 | Days 4 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Baker

11. Industry or business May Co.

FATHER
12. Name Sebastian Heinmuller.
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Damm,
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Margaret E. Heinmuller,
(b) Address 2726 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 22. 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director George W. Little,
(b) Address 2700 Edmondson Ave.

19 (a) JAN 20 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 17 - 1945, at 11:08 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16-1945 to 1-17-1945 and that I last saw him alive on 1-17-1945

Immediate cause of death: Uremia, Acidosis Severe, Dehydration. — Duration:
Due to: Chronic Glomerular nephritis.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: Probable Ca of Rectum + Bladder

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allen C. Wooden M. D.
Address W.B.G.H. Date signed 1-18-45

VS 150

G24925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G24925

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Chester (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rossie K. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No. 196-05-0233

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 23rd 1878

8. AGE: Years 66 67 | Months 10 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Deals Island Md (Town, county, and state)

10. Usual Occupation Steward at Maritime

11. Industry or business Commission

FATHER
12. Name Joshua Thomas
13. Birthplace Crisfield Md

MOTHER
14. Maiden Name Willie Johnson
15. Birthplace Md

16 (a) Informant Mrs. Warrington
(b) Address Darby Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21st 1945 (month) (day) (year)
(c) Cemetery or crematory St Peters Methodist
Location Hopewell Md

18 (a) Funeral director Leo G. Leach
(b) Address 1701-03 N Patterson Park Ave

19 JAN 20 1945 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18, 1945, at 12:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Jan 18 1945

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

G24926 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2501 Elsinor ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2501 Elsinor ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Lou Hulin

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	none —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single —

6 (b) Name of husband or wife — —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 3, 1933

8. AGE: Years	Months	Days	If less than one day
11	6	16	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name William W. Hulin
13. Birthplace Pa.

MOTHER
14. Maiden Name Frances Dixon
15. Birthplace Pa.

16 (a) Informant Mr. William W. Hulin
(b) Address 2501 Elsinor Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Greenmount Mausoleum
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md

19 (a) Lucy Livingston Williams, M.T. (Date rec'd by registrar) (b) Registrar

JAN 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-19- 1945, at 8 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Strangulation
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-19- at P. M.
(b) Where did injury occur? 2501 Elsinor ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Manual

23. Signature Howard J. Uhlein M.D.
Medical Examiner.
Date signed 1-20-45

VS 151

G24927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 C

Registered No. G24927

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Joseph's Hospital
(c) Hospital or institution: " "
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2417 Greenmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norward Allen Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years	Months	Days	If less than one day
37	36	-	hr. min.

9. Birthplace Wilmington Del.
(Town, county and state)
10. Usual Occupation Baker
11. Industry or business Golden Crust Product

FATHER
12. Name John F. Brown
13. Birthplace Delaware

MOTHER
14. Maiden Name Sarah B. Holett
15. Birthplace Delaware

16 (a) Informant Mrs John F. Brown
(b) Address 630 Oakesbury Ave

17 (a) Burial (b) Date thereof 1-22-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Christiana Cem.
Location Wilmington, Delaware

18 (a) Funeral director Mary no Woodyard
(b) Address 726 E. 22nd St.

JAN 20 1945
(Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/26 1944, to Jan. 1945, and that I last saw him alive on Jan. 7 1945

Immediate cause of death	Duration
Acute heart failure.	
Due to Rheumatic heart disease.	2
Due to	
Other Conditions Mitral and aortic insufficiency.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George W. Humphreys Jr. M. D.
Address 332 E. University Pkwy. Date signed 1/20/45

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. 621328

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Guilford (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rachael Green

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6 - 1877

8. AGE: Years 67 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Montgomery Co. (town, county, and state)

10. Usual Occupation Laundress.

11. Industry or business

MOTHER / FATHER

12. Name Chas. A. Green

13. Birthplace Montgomery Co.

14. Maiden Name Ella A. Adams.

15. Birthplace Montgomery Co.

16 (a) Informant Hattie Green

(b) Address Guilford Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21 - 45 (month) (day) (year)

(c) Cemetery or crematory Elkridge Cemetery Co

Location Howard Co.

18 (a) Funeral director Jno. H. C. White Co. Inc.

(b) Address Laurel Md.

19 (a) JAN 20 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/19 1945, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1945 to 1/19 1945, and that I last saw h.er alive on 1/18 1945

	Duration
Immediate cause of death Respiratory failure	1 day
Due to Cardiac failure	10 days
Due to Arteriosclerotic cardiovascular disease	
Other Conditions Frost bite gangrene feet & hands.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen A Storm M. D.

Address University Hospital Date signed 1/19/45

VS 150

C21323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a Registered No. C21323

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Every item is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution: Harford Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 years
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4700 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret A. Schaub

3 (b) If veteran, name war —

3 (c) Social Security Account No. — —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Jno. C. Schaub

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 2nd 1864

8. AGE: Years 80 | Months 9 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Louis Marshall
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Coehlman
15. Birthplace Germany

16 (a) Informant Mrs. Ruby Judith Woodbrook
(b) Address 2857 Woodbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director F. S. Wesselhoeft Son
(b) Address 300 Eastern Ave

19 JAN 20 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17th 1945; at 7.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jul 15 1944 to Jan 17 1945, and that I last saw him alive on Jan 10th 1945.

Immediate cause of death Broncho-Pneumonia — Duration 3 days

Due to

Due to

Other Conditions Fractured Femur — 8 months

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None Accident
(b) Date of occurrence April 1944 at M
(c) Where did injury occur? Home 4700 Harford Rd
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At home While at work? No
(Specify type of place)
(e) Means of injury Fall to floor

23. Signature L. L. Crosby M.D.

Address 5706 Harford Rd Date signed 1-19-45

VS 150

For Dr. J. Bubinski, by Thomas J. Wheeler, M.D.

G24930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G24930 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 South Greene St
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 131 N. Arch St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Williams or Nathan Hardy

3 (b) If veteran, name war

3 (c) Social Security Account No. — — —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	— —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1890

8. AGE: Years	Months	Days	If less than one day
About 55	—	—	hr. min.

9. Birthplace Grimesland North C. (Town, county, and state)

10. Usual Occupation Unknown -

11. Industry or business "

FATHER
12. Name William Ellison
13. Birthplace N. C.

MOTHER
14. Maiden Name Delia Hardy
15. Birthplace N. C.

16 (a) Informant Mrs. Viola James
(b) Address 131 Arch St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Annapolis Rd.

18 (a) Funeral director Lee Oder
(b) Address 4644 York Rd.

19 (a) (Informant or undertaker) Hunting for Williams Mgr Registrar

JAN 20 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/1/45 1945, at 7:19 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/31 1944 to 1/1 1945 and that I last saw him alive on 1/1 1945

Immediate cause of death Respiratory failure

Due to Pneumonia

Due to

Other Conditions Auricular fibrillation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pneumonia Consolidation Left Lower Lobe.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen A Hone M. D.
Address University Hospital Date signed 1/1/45

G24931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G24931

JO #91452

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 N. Franklintown Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Zeger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Thomas (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1888

8. AGE: Years	Months	Days	If less than one day
56	5	-0-	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ? Miller?(d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret ? (d)
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof 1-23 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Hedrick Rd

18 (a) Funeral director Ambrose Doe
(b) Address 414 N. Franklintown Rd
Huntington Williams, M.D. Registrar

19 (a) (Date received by local registrar) JAN 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 4, 1945, to Jan. 19, 1945, and that I last saw her alive on Jan. 19, 1945.

	Duration
Immediate cause of death Acute Heart failure c Bilateral Bronchopneumonia	
Due to Generalized Arteriosclerosis	
Due to Kidney failure due to Chronic nephritis	
Other Conditions Arteriosclerotic Gangrene Lt leg	

(Include pregnancy within 3 months of death)
Date of operation 1-6-45
Major findings of operation: Gangrene
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R Miller M.D.
Address 1-20-45 City Hosp. Date signed

G24932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24932 108

Registered No. G24932

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1436 Argyle Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1436 Argyle Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Arrington

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19 1903

8. AGE: Years 41 | Months 1 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name James Arrington
13. Birthplace Va.

MOTHER
14. Maiden Name Eliza Taylor
15. Birthplace Va.

16 (a) Informant Cora Gholson
(b) Address 1512 E Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 21 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Q A County Md.

18 (a) Funeral director Mrs. Robert A. Hill & Sons
(b) Address 1129 N. Caroline St.

19 (a) Date received (by registrar) JAN 21 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-17 1945 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1945 to 1-17 1945 and that I last saw her alive on 1-17 1945.

Immediate cause of death: Lobar Pneumonia — Duration: D/C
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature B. N. Habelman M. D.
Address 1215 Park Ave Date signed 1/19/45

G24933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24933 Registered No. 46 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford Co.
(c) City or town Perrymans (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 56 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice Bellamy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	married

6 (b) Name of husband or wife Melvin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-14-99

8. AGE: Years	Months	Days	If less than one day
45	11	5	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Luther Stilson

13. Birthplace N. C.

MOTHER 14. Maiden Name Cora Gaise

15. Birthplace N.C.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 21 45 (month) (day) (year)

(c) Cemetery or crematory

Location Wilmington N. Carolina

18 (a) Funeral director Mrs. Grace A. Ellis

(b) Address 1129 W. Caroline St.

19 (a) JAN 21 1945 (Date rec'd by registrar) Hunterton Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19, 1945, at 3:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5 1945 to Jan 19 1945 and that I last saw her alive on Jan. 19 1945.

Immediate cause of death	Duration
Carcinomatosis	
Due to Carcinoma of Stomach	2 yrs?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1-9-45

Major findings of operation: Impossible Ca of stomach - Carcinomatosis

If autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Bunch M. D.

Address J.H.H. Date signed 1-19-45

VS 150

G24934 G24934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1178

JO #72008

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs 10mos 28days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 Shore Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Austin Gardner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mollie (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1878

8. AGE: Years 66 | Months 6 | Days -1- | If less than one day hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: James
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Carrie Painter
15. Birthplace: Virginia

16 (a) Informant: Records, Baltimore City Hosp.
(b) Address: 4940 Eastern Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan. 20 1945 (month) (day) (year)
(c) Cemetery or crematory
Location: Alexandria, Va.

18 (a) Funeral director: H. E. Pennybacker
(b) Address: [illegible] Washington Boulevard, Md.

JAN 21 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19, 1945, at 4:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1942, to 1/19 1945, and that I last saw him alive on 1/19 1945.

Immediate cause of death	Duration
Hemorrhage into gastro intestinal tract	?
Due to Duodenal ulcer	?
Due to	
Other Conditions Gen. arterio-sclerosis (Include pregnancy within 3 months of death)	?

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Wm Kenneth Smith
Address Balt. City Hosp. Date signed 1/24/45 M. D.

VS 150

G24935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24935

Registered No. 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 do.
(e) Length of stay in Baltimore (yrs., mos., or days) 17

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 N. Smallwood (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ZELIG EISEN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Married

6 (b) Name of husband or wife Mary Eisen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
81	80		hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Harry Wolf Eisen
13. Birthplace Russia

MOTHER
14. Maiden Name Katie ?
15. Birthplace Russia

16 (a) Informant Morris Eisen
(b) Address 3200 N Hilton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan, 21, 1945 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levindon & Bros
(b) Address 1124-1126 W North Ave

19 (a) JAN 21 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/19/45 1945 at 9:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/17 1945 to 1/19 1945.
and that I last saw him alive on 1/19 1945

Immediate cause of death Cardiac Failure — Duration

Due to Arteriosclerotic Heart Disease & Nephritis

Due to

Other Conditions Fracture of Right Femur

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 45/3
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 1/16/45 at M
(c) Where did injury occur? Baltimore Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury Fall (Slipped + fell)
23. Signature Elmer [illegible]
Address Sinai Hospital Date signed 1/20/45

For Dr. J. R. Davis, by Howard J. Mendelsohn, M.D. X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24936 / 50

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 S. Green
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 S. Green St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alice Ross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife 1

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1887

8. AGE: Years 57 | Months 10 | Days 13 | If less than one day hr. min.

9. Birthplace Philadelphia Pa
(Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name Enoch R. Ridgely
13. Birthplace Frederick Co. Md

MOTHER
14. Maiden Name Sarah R. Ross
15. Birthplace Galatia Ill.

16 (a) Informant Charles L. Ross
(b) Address 610 S Green St

17 (a) (Burial, cremation, or removal) (b) Date thereof 1 [illegible] 45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemetery
Location Balto. Md.

18 (a) Funeral director Walter B. Scriggs
(b) Address 139 W Hamburg Street

19 (a) (Signature of local registrar) (b) Received JAN 21 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/17 1945, at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1944 to 1/17 1945, and that I last saw h alive on 1/16 1945.

Immediate cause of death Carcinoma Breast
Due to Lymphosarcoma
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hunt Townsley M. D.
Address [illegible] Date signed 1/18/45

G24937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G24937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4901 Monello Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4901 Monello Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Oscar C Preuss

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~. Married

6 (b) Name of ~~husband or~~ wife Marie E Preuss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2 1876

8. AGE: Years 68 | Months 3 2 | Days 2 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Builder
11. Industry or business Own Business

FATHER
12. Name (Unknown) Preuss
13. Birthplace Germany

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Kurt Preuss
(b) Address 2407 Halcyon Av

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1/23/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul st

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 21 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19th 1945, at 9:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1944 to Jan 19 1945 and that I last saw him alive on Jan 18 1945.

Immediate cause of death	Duration
Arteriosclerotic	unknown
Heart Disease.	
Due to Generalized	unknown
Arteriosclerosis	
Due to —	
Other Conditions none	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Dawson, M.D.
Address 4808 Harford Rd. Date signed 1/20/45 M. D.

G24938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G24938
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Guilford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Guilford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kunigunda M. Mehl

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: George Mehl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2 1863

8. AGE: Years 81 | Months 4 2 | Days 2 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Unknown Moelter
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Joseph G. Mehl
(b) Address 1200 Guilford Ave

17 (a) Burial (b) Date thereof 1/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) JAN 21 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19th 1945; at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June. 1944, to Jan. 19 1945
and that I last saw ~~him~~ alive on Jan 18 1945.

Immediate cause of death: Inforamtion of Lungs
Due to: Myocarditis
Due to:
Other Conditions: Malnutrition
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas H. Maguire M. D.
Address 14 E. Preston Date signed 1-20

VS 350

Verified 89 X 45

340 G24939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 131a

G24939 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) "

2. USUAL RESIDENCE OF DECEASED:
(a) State MAINE (b) County
(c) City or town AUGUSTA (If outside city or town limits, write RURAL and give town)
(d) Street No. 113 Winthrop St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Nelson Crosby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-18-77

8. AGE: Years	Months	Days	If less than one day
67		3	hr. min.

9. Birthplace Maine (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER
12. Name Edwood Crosby
13. Birthplace Maine

MOTHER
14. Maiden Name ? Perkins
15. Birthplace Maine

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date of (Burial, cremation, or removal) Jan 21 45 (month) (day) (year)
(c) Cemetery or crematory
Location Monmouth Maine

18 (a) Funeral director Henry N. Jenkins Sons Co
(b) Address McCulloch & Archibald

19 (a) JAN 21 1945 (Date received by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1945, at 3 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28- 1944 to 1-21 1945 and that I last saw her alive on 1-21- 1945

Immediate cause of death	Duration
UREMIA	
Due to ARTERIOLOSCLEROTIC NEPHRITIS	
Due to HYPERTENSIVE CARDIOVASCULAR DISEASE	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Laurie Dickson M.D.
Address Johns Hopkins Date signed 1/24/45

G24940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G24940 Registered No.

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A
(b) Street address 1002 E. Hoffman St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 58 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 E. Hoffman St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME (Theresa Voigt) Theresa Voigt

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widowed

6 (b) Name of husband or wife: Gustav Voigt
6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): Dec. 26, 1873

8. AGE: Years	Months	Days	If less than one day
71	0	23	..... hr. ..... min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business

FATHER
12. Name: (Lehman)
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Mrs. Lula G. Harp (Daughter)
(b) Address: 1002 E. Hoffman Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 23, 1945 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cemetery
Location: Frederick Rd.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

JAN 21 1945 (b) Huntington Williams M.D. Registrar
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/~~22~~ 19 1945, at 1:25 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Chronic Myocardial Degeneration

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ——— at ——— M.
(b) Where did injury occur? ———
(c) Did injury occur at home, on farm, industrial place, in public place? ——— While at work? ———
(d) Means of injury ———

23. Signature: [illegible] M.D.
Medical Examiner
Date signed 1/20/45

G24941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G24941
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3808 S. Hanover Street
(c) Hospital or institution:
2554
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3808 S. Hanover St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna B. Anthony

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Albert Wayne Anthony
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1870

8. AGE: Years 75 | Months 0 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Christopher Burrier
13. Birthplace Unknown

MOTHER
14. Maiden Name Minnie Hughes
15. Birthplace Maryland

16 (a) Informant Mrs. Gladys Heins
(b) Address 736 E. 36th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 22 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore County

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) JAN 21 1945 (Date received by Registrar) (b) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 1945, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/18, 1945, to 1/18 1945, and that I last saw h Dead on arrival alive on 19

Immediate cause of death	Duration
(a) Heart failure	
Due to (b) Hypertension	
Due to (c) Coronary Sclerosis	
Due to	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Rubin M. D.
Address 200 Balafax a Date signed 93d

G24942 ✓ G24942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mar Balto. Gen. Hospital 568
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 Broadway ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Layden (Frank Layden)

3 (b) If veteran, name war None

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Layden.

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Jan 25, 1882

8. AGE: Years 6x | Months 11 | Days 22 | If less than one day: hr. X min. X

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Highways Dept Balto City.

FATHER
12. Name William Layden
13. Birthplace Unknown

MOTHER
14. Maiden Name Annie Willie
15. Birthplace Unknown

16 (a) Informant Mrs. Martha Harris
(b) Address 1430 N. Chester St.

17 (a) Burial (b) Date thereof 1/23/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location E. North Avenue

18 (a) Funeral director George J. Smith Inc.
(b) Address 1735 Milford Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20- 1945; at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH: Fractured skull

Due to

Other Conditions: Amputation - leg, traumatic.
Multiple contusions, abrasions + bruises.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 1-19- at 4.59 P.M. 20/2

(b) Where did injury occur? Evergreen + Edmondson Aves

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Pedestrian, struck by Street Car.

23. Signature Howard J. Mellin M.D.
Medical Examiner.

Date signed 1-20-45

VS 151

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WHITE PLAINLY, WITH UNFADING INK.

G24943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G24943 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 E. Federal St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Yes.

3 (a) **FULL NAME** William O'Keefe (William Carroll O'Keefe)

3 (b) If veteran, name war None

3 (c) Social Security Account No. 218-16-6824

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Lillian Talbott

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) April 1, 1888

8. AGE: Years 56 | Months 9 | Days 19 | If less than one day ... hr. X X ... min. X

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Orderly

11. Industry or business - Sydenham Hosp.

FATHER 12. Name James W. O'Keefe

13. Birthplace Maryland

MOTHER 14. Maiden Name Margaret Carroll

15. Birthplace Kentucky

16 (a) Informant Mrs. Margaret Ballman

(b) Address 113 N Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Edmondson Ave

18 (a) Funeral director George J. Ruth Inc

(b) Address 1735 Hilford Ave

19 (a) ... (b) ... (Date filed by registrar) ... Registrar

JAN 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/20/45 19... at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10/45 19... to 1/20/45 19... and that I last saw h[im] alive on 1/20/45 19...

Immediate cause of death	Duration
(a) Acute dilatation of right ventricle, heart	
Due to (b) Respiratory failure - due	
Due to (c) Cerebral hemorrhage	
Due to (d) Hypertension and Arteriosclerotic cardiovascular disease.	

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D.W. Mintzer M. D.

Address Univ. Hosp. Date signed 1/24/45

X

624944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

624944

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Dr Thlaham Fairfield Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Chesapeake Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Charles Bowman

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Myrtle Leasure
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) March 24 1904

8. AGE: Years	Months	Days	If less than one day
40	9	25	.....hr. .....min.

9. Birthplace Harmon. W. Va
(Town, county, and state)
10. Usual Occupation Gage operator
11. Industry or business Shipyard

FATHER
12. Name Wm Bowman
13. Birthplace Va

MOTHER
14. Maiden Name Emma Porter
15. Birthplace W. Va

16 (a) Informant Mrs. M Bowman
(b) Address 3608 9th St

17 (a) Burial (b) Date thereof 1 / 14 / 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location Cumberland Md

18 (a) Funeral director Thos J Kenny
(b) Address Fuller & Gertrude

19 (a) JAN 21 1945 (b) Huntington Williams Reg
(Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 1945, at 5:00 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary Edema

Due to Chronic myocarditis

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 1-20-45

X

Every item of information should be carefully supplied. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

624945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. 624945

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Larry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business ?

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Police Dept.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 1-21-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1436 E. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Registrar

1945 No 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 1945, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Chest

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 16, 1945 10:15 A M.
(b) Where did injury occur? 1806 Patterson Park Ave
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? No
(d) Means of injury Shooting

23. Signature Robert L. Gutman M.D.
Medical Examiner.
Date signed 1-19-45

G24946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G24946 Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1229 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1229 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Gertrude White

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1881

8. AGE: Years 63 | Months 2 | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER 12. Name Samuel White
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Rebecca ? ? ?
15. Birthplace Baltimore, Md.

16 (a) Informant Raymond Carpenter
(b) Address 1229 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 21 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem. Pk
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George W. Holland
(b) Address 1631 Druid Hill Ave

JAN 21 1945 (Date filed by registrar) Huntington Williams, III Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1945, at 9.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to Jan 17 1945 and that I last saw h.. alive on Jan 17 1945

Immediate cause of death	Duration
Carcinoma of Stomach	2
secondary in Liver.	1
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edw. J. Wheatley M. D.
Address 1230 Druid Hill Ave Date signed 11/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106B

G24947 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
3124 Baker St.
(b) Street address.....
(c) Hospital or institution:
.....
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3124 Baker St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME JAMES LOUIS BELL

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary or Minnie G. Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1869

8. AGE: Years	Months	Days	If less than one day
75	9	9	.....hr. .....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Interior Decorator
11. Industry or business Self

FATHER
12. Name James Isaac Bell
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Fanny Marshall
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Maty G. Bell
(b) Address 3124 Baker St.

17 (a) Burial (b) Date thereof 1/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 21 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Jan. 18, 1945, at 2:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1943 to January 18 1945, and that I last saw him alive on January 18 1945.

Immediate cause of death	Duration
Bronchitis	2 yrs
Due to.....	
Due to.....	
Other Conditions Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: N C
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Leon Asleman M. D.
Address 1201 Pepler Hose St Date signed 1-19-45

VS 150

X

G24948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E G24948 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 W. Northern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha A. Thiemeyer.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1874

8. AGE: Years	Months	Days	If less than one day
70	6	15	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation House Keeper
11. Industry or business SELF

FATHER
12. Name John H. Thiemeyer
13. Birthplace Germany

MOTHER
14. Maiden Name Cecelia Meyers
15. Birthplace Germany

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof 1/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) 1945 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/20 1945 at 10:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1945 to 1/20 1945, and that I last saw h alive on 1/20 1945.

Immediate cause of death	Duration
Cardio-resp Failure	
Pneumonia & Tamponade	
Due to Probable Abdominal	?
CA Metastasis to Liver	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl K. Jackson M. D.
Address Mercy Hosp Date signed 1/20/45

G24949 ✓ G24949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Pkwy. & Tudor Arms
(c) Hospital or institution:
Tudor Arms Apts.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Tudor Arms Ave. & University Pkwy.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DR. HENRY B. KOLB

3 (b) If veteran, name war: -

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Ethel Kolb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1882

8. AGE: Years	Months	Days	If less than one day
62	5	20	hr. min.

9. Birthplace Galesville, Md.
(Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Galesville, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Ethel Kolb
(b) Address Tudor Arms Apts.

17 (a) Burial (b) Date thereof 1/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(a) JAN 21 1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18, 1945, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1943, to Jan. 1945; and that I last saw him alive on Jan. 18, 1945.

Immediate cause of death	Duration
Coronary insufficiency	acute
Due to Arteriosclerotic heart disease	10-15 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Edward Leach M. D.
Address 14 E. Eager St. Date signed 1/19/45

Huntington Hillsboro, W. Va.

X

G24950 ✓ G24950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green Street
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3111 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John M Jernigan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W.	Married

6 (b) Name of husband or wife Mildred G.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1895

8. AGE: Years	Months	Days	If less than one day
49	10	12	hr. min.

9. Birthplace Green Sea, S. Carolina (Town, county, and state)
10. Usual Occupation Field Mgr.
11. Industry or business Park Davis Co.

FATHER
12. Name John Jernigan
13. Birthplace Couth Carolina

MOTHER
14. Maiden Name Martha Mc Dermott
15. Birthplace South Carolina

16 (a) Informant Mrs. Mildred G. Jernigan
(b) Address 3111 N. Calvert St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/21/45 (month) (day) (year)
(c) Cemetery or crematory
Location Charleston South Carolina

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pa. aves

19 (a) JAN 24 1945 (Date filed by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20 1945, at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1944 to 1-20 1945, and that I last saw him alive on 1-20 1945.

Immediate cause of death	Duration
Resp Failure	
Due to Pulmonary carcinoma	
Due to Brain metastatic carcinoma	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Elias M. D.
Address Univ. Hospital Date signed 1-21-45

Huntington Williams, M.D.

624951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

624951 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 720 Linnard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 720 Linnard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vespher A. Aram

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Married

6 (b) Name of husband or wife Charles H. Aram
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1873

8. AGE: Years	Months	Days	If less than one day
71	11	29	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business Own Home

FATHER
12. Name Bernard Donnelly
13. Birthplace Md.

MOTHER
14. Maiden Name Virginia Freeman
15. Birthplace N.C.

16 (a) Informant Mrs. Charles H. Aram
(b) Address 720 Linnard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 22/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry H. Mitzke
(b) Address 4101 E Monument Ave

19 JAN 22 1945 (Date received) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19/45 19 , at 2:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2nd 1944 to Jan 19th 1945, and that I last saw her alive on Jan 19th 1945

Immediate cause of death Myocarditis — Duration 2 Months

Due to Unknown.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes; fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Conrad Bode M. D.
Address 1900 Maryland Ave Date signed 1-19-45

VS 150

624952 445989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66B

624952 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
Baltimore City, Maryland

Street address.....

Hospital or institution:
JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days).....

(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Harford

(c) City or town Havre-de-Grace
(If outside city or town limits, write RURAL and give town)

(d) Street No. 554 Revolution St
(If rural give location)

(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Howard Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-1-41

8. AGE: Years 3 | Months 3 | Days 19 | If less than one day .....hr. .....min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER 12. Name Clarence Miller

13. Birthplace S. Co.

MOTHER 14. Maiden Name Pauline Hawkins

15. Birthplace Md

16 (a) Informant Friends.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 1/23/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. James Cemetery

Location Havre de Grace Md

18 (a) Funeral director Elmer E Bullock

(b) Address Havre de Grace, Md

19 JAN 22 1945 (b) Huntington, W. Va.
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan-20 1945, at 3.25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-10 1944 to Jan-20 1945 and that I last saw him alive on Jan-20 1945

Immediate cause of death	Duration
Terminal Pneumonia	
Due to Exanthematous of Generalized	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: Generalized Exanthematous

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at..... M

(c) Where did injury occur?.....
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)

(e) Means of injury.....

23. Signature Victor A. Najjar M. D.

Address Johns Hopkins Hosp. Date signed 1-22-45

VS 190

(over)

G24953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G24953

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 Garrison Blvd.
(c) Hospital or institution: Ventura Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3213 Brightwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony E. Heidt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Sarah E. Heidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2, 1863

8. AGE: Years	Months	Days	If less than one day
81	4 5	16	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Market.

FATHER
12. Name Anton Heidt
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Irvin B. Heidt
(b) Address 3213 Brightwood Ave

17 (a) Burial (b) Date thereof 1-22-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Heights Ave

19 JAN 22 1945 (b) Huntington Williams, M.D.
(Date received by local registrar) (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18, 1945, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1945 to 1/18 1945
and that I last saw him alive on 1/18 1945

Immediate cause of death	Duration
Myocarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur W. Mac
Address 3862 Dalfield Ave Date signed 1/21/45 M. D.

G24954

BALTIMORE CITY HEALTH DEPARTMENT X V G24954

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkins Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ingleside Ave & Duel Highway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Hicks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept - 10 - 1889

8. AGE: Years 55 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Augusta Co. Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Mr Wordon
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Harry Hicks
(b) Address Ingleside Ave & Duel Highway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 - 23 - 45 (month) (day) (year)

(c) Cemetery or crematory
Location Richmond Virginia

18 (a) Funeral director John E Milby Inc
(b) Address 2435 E Oliver St

19 (a) Registrar Huntington Williams M.D.

JAN 22 1945

VS 15a

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/20 19 45 at 10:23 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/6 19 45 to 1/21 19 45, and that I last saw her alive on 1/21 19 45.

Immediate cause of death: Acute heart failure — Duration

Due to: Hypertensive Cardio-vascular disease

Due to: Chronic Glomerulo Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J Bryan

Address St Agnes Hosp Date signed 1/20/45

G24955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 c

G24955 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd.
(c) Hospital or institution: Sydenham Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 E. Monument St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country China

3 (a) FULL NAME Mond Hang Lee

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Chinese	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 | 17 | 1930

8. AGE: Years	Months	Days	If less than one day
14	3	4	hr. min.

9. Birthplace Newyork New York (Town, county, and state)

10. Usual Occupation Scholar

11. Industry or business

FATHER — 12. Name	Ah Hing Lee
FATHER — 13. Birthplace	Canton China
MOTHER — 14. Maiden Name	Yee Shee Lee
MOTHER — 15. Birthplace	Canton China

16 (a) Informant Mother

(b) Address 1208 E. Monument St.

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 1-24-45 (month) (day) (year)

(c) Cemetery or crematory Evergreen Location Long Island + New York

18 (a) Funeral director Jack Lewis Inc

(b) Address 1429 E Baltimore St

19 (a) Date received JAN 22 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/21 1945, at 1:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9 1945 to 1/21 1945, and that I last saw her alive on 1/21 1945.

Immediate cause of death Cardiac Failure — Duration

Due to Diphtheritic Myocarditis — 10 days

Due to Bronchial Pneumonia

Due to —

Other Conditions Rheumatic Fever

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.

Address Sydenham Hosp. Date signed 1-21-45

G24956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G24956 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1020 Russell St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 Russell St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Master

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married.

6 (b) Name of husband or wife Joseph Master

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1904

8. AGE: Years 40 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Albany, N.Y.
(Town, county, and state)

10. Usual Occupation Packer

11. Industry or business Marble Factory

FATHER
12. Name Julius Gulas
13. Birthplace Hungary

MOTHER
14. Maiden Name Ann Bodecy
15. Birthplace Hungary

16 (a) Informant Miss Katherine Gulas
(b) Address 5010 Foster Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Sunset Memorial
Location Clarksburg, W. Va.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 461 Park Heights Ave

JAN 22 1945 Huntington, W. Va.
Date received by Local Registrar — Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21 1945, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/13 1945, to 1/21 1945, and that I last saw h~~er~~ alive on 1/20 1945.

Immediate cause of death: General carcinomatosis — Duration: 2

Due to —

Due to —

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury 30

23. Signature R. V. Rouzle M. D.
Address 1226 Hanover St Date signed 1/21/45

G24957 ✓ G24957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95 C Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 Druid Hill ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Derricks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Robert Derricks
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1880

8. AGE: Years 64 65 | Months 11 | Days 16 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Landis Mitchell
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma Dijeas
15. Birthplace Balto. Md.

16 (a) Informant Robert Derricks
(b) Address 504 Druid Hill Ave

17 (a) Burial (b) Date thereof Jan. 23, 19
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location 420 Simpson circle

18 (a) Funeral director A. Halstead
(b) Address 968 Druid Hill Ave

19 (a) JAN 22 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19, 1945, at 8.7 M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] to [illegible] and that I last saw [illegible] alive on [illegible]

Immediate cause of death Coronary thrombosis | Duration Hours

Due to

Due to

Other Conditions Syphilis Aorta Lues

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. Leroy Sellman M.D.
Address [illegible]

VS 150

G24958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

Registered No. G24958

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~1811~~
(c) Hospital or institution: Univ. Hospital 15"
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Lawrence St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROLAND RAY (McCoy)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex 14 | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. INFANT

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) march 2, 1944

8. AGE: Years | Months 10 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Samuel Ray

13. Birthplace Tenn

MOTHER 14. Maiden Name Mary Nickens

15. Birthplace Va

16 (a) Informant Mary McCoy

(b) Address 1814 Lawrence St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-46 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn, Md.

Location

18 (a) Funeral director George E. Kelson

(b) Address 1303 Pennsylvania Ave Baltimore, Md.

JAN 22 1946 (Date received) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 1945, at 3 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12 1945 to 1-20 1945 and that I last saw h/ alive on 1-20 1945.

Immediate cause of death Tuberculous meningitis — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature RBN agreement M. D.

Address Univ. Hosp Date signed 1/20/45

VS 150

G24959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G24959

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the exact causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1537 Leslie St Dot.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1537 Leslie St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Armstrong

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25, 1894

8. AGE: Years	Months	Days	If less than one day
50	1	20	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Walter Weaver
13. Birthplace Virginia

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant George Armstrong
(b) Address 1537 Leslie St.

17 (a) Burial (b) Date thereof 1-23-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director George H. Nelson
(b) Address 1303 Pressman St

19 JAN 22 1945 (b) Courtney Van Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/18 1945, at 10:25 AM

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester J. Lubinski M.D.
Medical Examiner.
Date signed 1/18/45

VS 151

624960
46366

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1335 Registered No. 624960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town Brooklyn (If outside city or town limits write RURAL and give town)
(d) Street No. 176 Prospect Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard B. Glascoe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	married

6 (b) Name of husband or wife Ida M. Glascoe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-25-98

8. AGE: Years	Months	Days	If less than one day
46	11	25	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Glascoe
13. Birthplace Md.

MOTHER
14. Maiden Name Martina Gilliam
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Md

18 (a) Funeral director Geo. G. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) JAN 22 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 19 1945 at 9.31 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-26 1944 to Jan 19 1945 and that I last saw him alive on Jan 19 1945

Immediate cause of death	Duration
a Uremia	
Due to Congenital polycystic disease of the kidneys.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Hattes
Address Johns Hopkins Hosp Date signed 1/20/45 M. D.

VS 150

G24961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

AB-87633 / 3B

Registered No. G24961

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8mos-22 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Laurens St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Hill

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-14-0097

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30-1920

8. AGE: Years	Months	Days	If less than one day
24	2	17	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Waitress

11. Industry or business

FATHER
12. Name Samuel Hill
13. Birthplace Md.

MOTHER
14. Maiden Name Marie Buchanan
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-45 (month) (day) (year)
(c) Cemetery or crematory Dr. Peters
Location Balto. Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Belnord Ave.

19 (a) JAN 22 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16- 1945, at 10.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-25 1944 to 1-16 1945 and that I last saw her alive on 1-16- 1945

Immediate cause of death	Duration
Pulmonary tuberculosis	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto. City Hosp. Date signed 1/17/45

24962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G24962

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 S. GLOVER ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 708 S. GLOVER ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: EUELL RIDGELL

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife ANNIE RIDGELL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 4 1855

8. AGE: Years	Months	Days	If less than one day
89	4	15	hr. min.

9. Birthplace ST. MARYS CO. MD.
(Town, county, and state)
10. Usual Occupation CARPENTER
11. Industry or business

FATHER
12. Name THOMAS RIDGELL
13. Birthplace MD.

MOTHER
14. Maiden Name MORIAH GREENWELL
15. Birthplace MD.

16 (a) Informant ADRIAL PRICE (DAUGHTER)
(b) Address 708 S. GLOVER ST.

17 (a) BURIAL (b) Date thereof JAN. 22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Zeiler, INC.
(b) Address 403 S. MOLFE ST.

JAN 22 1945 (b) Huntington Williams M.D.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 19 1945, at 6/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/12 1945 to 1/19 1945 and that I last saw him alive on 1/18 1945

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams M. D.
Address 1123 E. Pratt St. Date signed 1/20/45

VS 150

G24963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G24963

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1820 CLIFTON AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 44 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 CLIFTON AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MORRIS ROSENFELD

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-05-4714

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MINNIE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace RUSSIA
(Town, county, and state)
10. Usual Occupation SALESMAN
11. Industry or business

FATHER
12. Name MAX ROSENFELD
13. Birthplace RUSSIA

MOTHER
14. Maiden Name DORA
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (b) Date thereof 1-22-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HERRING RUN
Location PHIL RD + BOWLEYS LANE

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST

19 (a) JAN 22 1945 Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-21-1945, at 11 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943, to 1-21 1945
and that I last saw h alive on 1/21 1945

Immediate cause of death
a) cute coronary thrombosis

Due to

Due to

Other Conditions Cerebral + renal arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
15 minutes

?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams

Address 2904 Reisterstown Rd Date signed 1/22/45

624964

624964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160A

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write correct age in each case. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Caitland Ave.
(c) Hospital or institution: Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10dy
(e) Length of stay in Baltimore (yrs., mos., or days) 10dy

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 735 Aisquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy PELOVITZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1945

8. AGE: Years	Months	Days	If less than one day
			11 hr. 30 min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation newborn
11. Industry or business

FATHER
12. Name Maurice Pelovitz
13. Birthplace Lithuania

MOTHER
14. Maiden Name Libby Bass
15. Birthplace Baltimore Md.

16 (a) Informant Libby Pelovitz
(b) Address 735 Aisquith St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Memory Park
Location

18 (a) Funeral director Sol Levine and Bro
(b) Address 1439 E. Balto St.

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20 1945, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 1945, to 1/20 1945, and that I last saw h[illegible] alive on 1/20 1945.

Immediate cause of death Intrauterine Hem.

Due to

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Intrauterine Hem.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Raymond B. Walker M. D.
Address Sinai Hosp. Date signed 1/21/45

624965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

624965 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. If exact age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland McKenna Home

(b) Street address 212 Stoney Run Lane

(c) Hospital or institution: McKenna Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County none

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3105 Clifton Ave.
(If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Shaffer Amos

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1874

8. AGE: Years	Months	Days	If less than one day
70	7	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Charles L. Amos
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Louisa Shaffer
15. Birthplace Baltimore, Md.

16 (a) Informant Anna May Webster
(b) Address 3105 Clifton Ave.

17 (a) Burial (b) Date thereof 1/22/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Greenmount
Location Greenmount Ave. & Oliver St.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1908 Eutaw Place

JAN 22 1945
(Date rec'd by registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20 1945 at 7 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Octo 22 1943 to Jan 19 1945 and that I last saw her alive on Jan 19 1945

Immediate cause of death: Chronic myocarditis — Duration 5 yrs

Due to: Arterio sclerosis — 20 yrs.

Due to:

Other Conditions: Hypertension —
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature [signature] M. D.

Address 3403 Garrison Blvd. Date signed

624966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

624966
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 HILTON ROAD
(c) Hospital or institution:
18 months
(d) Length of stay in hospital or inst. (yrs., mos., or days) ######
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 HILTON ROAD (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMILY R. BOOZ
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife THOMAS H. BOOZ
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 28. 1874

8. AGE: Years	Months	Days	If less than one day
70	#7 6	22	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name PAUL RUSKER
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name LAVINIA LEMKE
15. Birthplace BALTO. MD.

16 (a) Informant ROBERTA M. KING
(b) Address 3226 GWYNNS FALLS PARKWAY

17 (a) cremation (Burial, cremation, or removal) (b) Date thereof JANY 22. 1945 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location 3801 FREDERICK AVE.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 EUTAW PLACE

19 JAN 22 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20/45 19 , at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944, to Jan 20 1945, and that I last saw h~~e~~r alive on Jan 19 1945.

Immediate cause of death	Duration
Cerebral hemorrhage and paralysis	2 days
Due to advanced arteriosclerosis	?
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hallas E. Dunbar M. D.
Address 2200 GARRISON BOULEVARD Date signed

VS 150

HERRILKO

G24967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G24967

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1

(c) Hospital or institution JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Pa (b) County

(c) City or town Leesburg (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dolores Herrilko

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-8-30.

8. AGE: Years 14 Months 1 Days 13 If less than one day hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation School child.

11. Industry or business

FATHER 12. Name Michael Herrilko

13. Birthplace Pa.

MOTHER 14. Maiden Name Mary Batko

15. Birthplace Pa

16 (a) Informant Friends.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof January 24 46 (month) (day) (year)

(c) Cemetery or crematory West Leesburg Cem

Location West Leesburg Pa

18 (a) Funeral director John Quitadamo & Sons

(b) Address 1606 Eutaw Place

19 (a) Date received by local registrar JAN 22 1946 (b) Signature Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-21-1945 at 6 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19-1945 to 1-21-1945, and that I last saw h alive on 1-21-1945.

Immediate cause of death Anemia and anemia

Due to Hepatic cirrhosis and necrosis.

Due to Epidemic Hepatitis

Other Conditions Jaundice & ascites

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ross L. McLean M.D.

Address J. H. H. Date signed 1-21-45

X

G24968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157 a

Registered No. G24968

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 75 days
(e) Length of stay in Baltimore (yrs., mos., or days) 75 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Steelton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Madeline Cave

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-6-44

8. AGE: Years	Months	Days	If less than one day
2½ months	2½	14	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Kenneth L. Cave
13. Birthplace Md.

MOTHER
14. Maiden Name Madeline Frost
15. Birthplace Md.

16 (a) Informant Mother
(b) Address 1119 Steelton ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 22-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Hamland Cem.
Location Dundalk ave & Grove
18 (a) Funeral director John E. Groves
(b) Address 3000 E. Baltimore
19 (a) JAN 22 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20, 1945 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6-1944 to 1-20-1945 and that I last saw her alive on 1-20-1945.

Immediate cause of death	Duration
Respiratory failure	
Increase Intracranial Pressure	
Due to Hydrocephalus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Allen C. Wooden M. D.
Address W. B. G. H. Date signed 1-20-45

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6 24969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. 6 24969

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division st.
(c) Hospital or institution:
President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1343 Gilmore st.
(If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Redfern

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-6-45

8. AGE: Years	Months	Days	If less than one day
			3 hrs. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wilson Redfern
13. Birthplace Chesterfield S.C.

MOTHER
14. Maiden Name Genevieve Jones
15. Birthplace Philadelphia Pa.

16 (a) Informant Genevieve Redfern
(b) Address 1343 Gilmor st

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address Huntington Williams, M.D.

JAN 22 1945
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6-1945, at 9 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6-45 1945, to 1-6-1945, and that I last saw him alive on 1-6-1945

Immediate cause of death	Duration
Atelectasis of lungs	
Due to Unknown	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy Collapsed lungs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. H. Pendleton M. D.
Address President Hosp. Date signed 1-10-45

VS 150

Kept for anatomical purposes. X

G24970 SHINSKY

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93 E

G24970 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 N. Robinson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 N. Robinson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Paul Shinsky

3 (b) If veteran, name war: 1st World War

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of ~~husband or~~ wife Helen Clara

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Feb. 29, 1896

8. AGE: Years 48 | Months 10 | Days 20 | If less than one day: hr. min. 21

9. Birthplace Lycoming, Pa. (Town, county, and state)

10. Usual Occupation Miner

11. Industry or business coal

FATHER
12. Name Jacob Shinsky
13. Birthplace Poland

MOTHER
14. Maiden Name Antoinette Kuryawa
15. Birthplace Poland

16 (a) Informant Helen Clara Shinsky
(b) Address 415 N. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/45 (month) (day) (year)
(c) Cemetery or crematory Balto National Cem
Location Frederick Rd.

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

19 (a) JAN 22 1945 (Date received by Registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20 1945, at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to Jan 20 1945, and that I last saw h~~im~~er alive on Jan 20 1945.

Immediate cause of death myocardial insufficiency — Duration 2 days

Due to carditis — ?

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. C. Schlicht, M. D.
Address 447 N. Kenwood Ave Date signed 1/20/45

X

624971
34175

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 56E

Registered No. 624971

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Belair
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Claudine Orr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Joseph Orr

6 (c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): 11-15-24

8. AGE: Years: 20 | Months: 2 | Days: 6 | If less than one day: hr. min.

9. Birthplace: N C
(Town, county, and state)

10. Usual Occupation: H. W.

11. Industry or business

FATHER
12. Name: Cleo F. Edwards
13. Birthplace: N C

MOTHER
14. Maiden Name: Clara Gamble
15. Birthplace: N C.

16 (a) Informant: records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: Belair Md.
Undertaker or funeral director: Bailey
(b) Address: Md

19 JAN 22 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 21 - 1945 at 7 00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10- 1945 to 1-21- 1945 and that I last saw her alive on 1-21- 1945.

Immediate cause of death: TOXEMIA + Shock (Post-Operative) — Duration: 4 days
Due to:
Due to:
Other Conditions: Pheochromocytoma — 2 Yrs
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation: Pheochromocytoma
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Alan C. Woods Jr.
Address: Johns Hopkins Hosp. Date signed 1/21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

624972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93-D

624972 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3725 Falls Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3725 Falls Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie E Howbell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband ~~or wife~~ Wm. C Howbell
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Sept 8 1867

8. AGE: Years	Months	Days	If less than one day
77	4	12	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own home

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name "
15. Birthplace "

16 (a) Informant Mr Wm. C Howbell
(b) Address 3725 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23/45 (month) (day) (year)
(c) Cemetery or crematory Mallows
Location Carroll Co Md

18 (a) Funeral director Edw Clipton
(b) Address Hampstead Md

19 (a) JAN 22 1945 (b) Huntington Millwood, Md
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1, 1945 to Jan 20 1945 and that I last saw h[illegible] alive on Jan 19 1945

Immediate cause of death	Duration
Heart Failure due arteriosclerosis	
Due to Heart Disease and	
Due to Bronchopneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Leonard Wallenstein M. D.
Address 898 W 36th Date signed 1/20/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G24973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G24973 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkins Ave.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3403 Greenmount Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Grace Zemsker

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-8442

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife George H Zemsker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1903

8. AGE: Years 41 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Co. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Augustus Hunt
13. Birthplace Baltimore Co.

MOTHER 14. Maiden Name Margaret Gregory
15. Birthplace Baltimore Co.

16 (a) Informant George H Zemsker
(b) Address 2303 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/45 (month) (day) (year)

(c) Cemetery or crematory Forest Baptist
Location Baltimore Co.

18 (a) Funeral director J. Melville Jenkins
(b) Address 2713 Kirk Ave

19 (a) JAN 22 1945 (b) Huntington Williams Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/20 1945, at 8.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9 1945 to 1/20 1945. and that I last saw her alive on 1/20 1945.

	Duration
Immediate cause of death Hemorrhage	
Due to Metastatic Carcinoma	
Due to Carcinoma of Cervix	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma of Cervix

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard W. Steele M.D.

Address St Agnes Hospital Date signed 1/24/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

G24974 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp. 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 803 W. Lombard (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry E. Chaney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Florence Chaney

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Aug 14, 1904

8. AGE: Years 40 | Months 5 4 | Days 5 27 | Under 1 day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Samuel Chaney
13. Birthplace Md.

MOTHER
14. Maiden Name Bessie Johnson
15. Birthplace Md.

16 (a) Informant Florence Chaney
(b) Address 803 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 22/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Harry A. Witzke
(b) Address 4401 Edmondson Ave

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

JAN 22 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/19 1944, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1944 to 1/19 1944, and that I last saw h/ M alive on 1/19 1944.

Immediate cause of death Brain tumor
c hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Brain tumor c hemorrhage

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Carl Myers M. D.
Address Franklin Sq. Hosp. Date signed 1/19/44

X

G24975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

Registered No. G24975

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 N Dallas
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colo

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years 87 | Months | Days | If less than one day hr. min.

9. Birthplace Calvert Co., Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Enoch White
13. Birthplace Calvert co, md

MOTHER
14. Maiden Name Annie Jones
15. Birthplace Calvert co, Md

16 (a) Informant Isaiah White
(b) Address 621 N Dallas

17 (a) Burial (b) Date thereof Jan 22-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto Co Md

18 (a) Funeral director Robert E Williams
(b) Address 1515 McElderry St

19 (a) JAN 22 1945 (b) Huntington Ave
(Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1945, at 8 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1945 to Jan 18 1945 and that I last saw alive on Jan 18 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 6 Days

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J Edward Fisher M. D.
Address 2 E Monument St Date Jan 24 1945

G24976 Dorch

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G24976

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 W. Franklin St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Dorch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years 33 | Months | Days | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Robert Dorch
13. Birthplace South Carolina

MOTHER
14. Maiden Name Sarah Trotter
15. Birthplace South Carolina

16 (a) Informant Jennie Richburg (sister)
(b) Address 1515 W. Lexington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 22, 1945 (month) (day) (year)
(c) Cemetery or crematory Dorchester
Location South Carolina

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 JAN 22 1945 Registrar Washington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 1945 at 12 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 16 1945 to Jan 19 1945, and that I last saw h.im alive on Jan. 19 1945.

Immediate cause of death Respiratory Failure — Duration

Due to Tyberculous Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Tuberculous pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Millard T. Graland Jr. M.D.
Address University Hospital Date signed 1-19-45

G24977 ✓ G24977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 E. Randall St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 E. Randall St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mary E. Barrett (GRANES)

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband ~~or wife~~ THOMAS BARRETT
6 (c) If alive, give age 59 years
7. Birth date of deceased (mo., day, yr.) AUGUST 13, 1897

8. AGE: Years	Months	Days	If less than one day
67 66	5	6	..... hr. ..... min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation HOUSE WORK
11. Industry or business AT HOME

FATHER
12. Name JOHN GRANES
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARY ALLEN
15. Birthplace MARYLAND

16 (a) Informant MR. GEORGE SAUNDERS
(b) Address 1334 HANOVER ST.

17 (a) Burial (b) Date thereof Jan. 22, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.
18 (a) Funeral director John L. Dennyhue
(b) Address 715 Light St

19 (a) JAN 22 1945 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/19 1945, at 2:55 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH .....
Coronary Occlusion.

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature George B. Randall M.D.
Medical Examiner.
Date signed 1/20/45

624978

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 90B

624978
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 530 W. Saratoga
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 530 W. Saratoga
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dilia Moore
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race Col
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1877
8. AGE: Years 68 67 | Months | Days | If less than one day ..... hr. ..... min.
9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant John Moore
(b) Address 530 W. Saratoga St
17 (a) Burial (b) Date there Jan 22 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location
18 (a) Funeral director Elroy O Wilson
(b) Address 1000 S Bradley Ave
19 (a) (b) Registrar
(Date rec'd by registrar) JAN 22 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1945; at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1945, to Jan 17 1945, and that I last saw him alive on Jan 16 1945.

Immediate cause of death Pericarditis

Duration
Days

Due to

Due to

Other Conditions Asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Stewart M. D.
Address 632 Fremont Ave Date signed Jan 20 1945

G24979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G24979

Registered No.

EO #90238

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 272 N. Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Renett Mickey or Rennett Mickey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1924

8. AGE: Years 20 | Months -5- | Days 22 | If less than one day ... hr. ... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Fulton Mickey
13. Birthplace: Va.

MOTHER
14. Maiden Name: Bessie Pullem
15. Birthplace: Va.

16 (a) Informant: Records, Baltimore City Hosp.
(b) Address: 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 22 45 (month) (day) (year)
(c) Cemetery or crematory: W. F. Calvery
Location

18 (a) Funeral director: Elroy O. Wilson
(b) Address

19 (a) 1000 (Date rec'd by registrar) (b) Brantley Co. (Registrar)

JAN 22 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18, 1945, at 4:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16, 1944 to Jan. 18, 1945, and that I last saw her alive on Jan. 18, 1945.

	Duration
Immediate cause of death: Pulmonary tuberculosis	2 yrs
Due to	
Due to	
Other Conditions: Intestinal tbc	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: confirmatory

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Harold Kellam M. D.
Address: Balt. City Hosp. Date signed 1/19/45

G24980

G24980
AB-91687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7hrs-5min
(e) Length of stay in Baltimore (yrs., mos., or days) 16yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town) 417 N. Ann St.
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Solomon Banks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife: Helen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 24-1897

8. AGE: Years	Months	Days	If less than one day
47	3	26 25	hr. min.

9. Birthplace: Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Promus Banks (D)
13. Birthplace: Va.

MOTHER
14. Maiden Name: Annie Hanes
15. Birthplace: Va.

16 (a) Informant: Baltimore City Hospitals (Records)
(b) Address: 4940 Eastern Ave.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 1/23/45 (month) (day) (year)
(c) Cemetery or crematory
Location: Norfolk, Virginia

18 (a) Funeral director: Mrs Ida Bailey
(b) Address: 1421 Jefferson St

19 (a) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19- 1945, at 11.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19- 1945 to 1-19 1945, and that I last saw h im alive on 1-19-45 1945

Immediate cause of death	Duration
Due to Pulmonary Tuberculosis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Leo A. Durand M. D.
Address: Baltimore, Md Date signed 7/20/45

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 180

G24981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24981
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1623 E 25th St D.O.A.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 E. 25th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H Darsch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Edith L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-21-1873

8. AGE: Years 71 | Months 9 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore - Md
(Town, county, and state)

10. Usual Occupation Retired -

11. Industry or business Gas & Electric Co.

FATHER
12. Name Philip Darsch
13. Birthplace Md.

MOTHER
14. Maiden Name Frances Dolphin
15. Birthplace Md.

16 (a) Informant Mr. Earl Darsch
(b) Address 5302 Elsrode Ave-14

17 (a) Burial (b) Date thereof 1-22-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cedar Hill
Location Baltimore - A.G.Co.

18 (a) Funeral director Leonard J. Kuck
(b) Address 5303 Harford Rd. 14

19 (a) ..... (b) ..... Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/19 1945, at 12 30 P M

21. I certify that I took charge of the remains described above, held an Inspection - Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 1/19/45

VS 151

Dr. White
3005 G24982 St.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49A

G24982
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5402 Hamlet Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5402 Hamlet Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgiana Webster

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Charles R. Webster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-22-1858

8. AGE: Years	Months	Days	If less than one day
86	9	28	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Nicholas Lynch
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie M. Hunter
15. Birthplace Maryland

16 (a) Informant Mrs. Edna W. Struth
(b) Address 5402 Hamlet Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Huck
(b) Address 5306 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

JAN 22 1945

Huntington Hilleary

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1942, to Jan. 19, 1945, and that I last saw her alive on Jan. 19 1945.

Immediate cause of death Arteriosclerosis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mabel White M. D.
Address 3005 Ward St Date signed Jan. 20 1945

G24983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G24983

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(c) City or town Parkville (If outside city or town limits, write RURAL and give town)
(d) Street No. 8001 Temple Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George A. Ryder

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Harriett Z.
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) May 30. 1870

8. AGE: Years	Months	Days	If less than one day
74	7	21	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name David J. Ryder
13. Birthplace N.J.

MOTHER
14. Maiden Name Mary A. Hunt
15. Birthplace Md

16 (a) Informant Mrs Harriett Z. Ryder
(b) Address 8001 Temple Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23, 45 (month) (day) (year)
(c) Cemetery or crematory Oakdown
Location Baltimore

18 (a) Funeral director L. J. Rucks
(b) Address 5305 Hartford Rd

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20 1945, at 11:25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1945, to 1-20 1945, and that I last saw him alive on 1-20 1945.

Immediate cause of death Coronary occlusion — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address Md. Gen. Hosp. Date signed 1-20-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Alessi G24984

G24984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 16

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2811 Westfield Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2811 Westfield Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Leonard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 6, 1888

8. AGE: Years	Months	Days	If less than one day
56	10	14	Hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business City of Baltimore

MOTHER | FATHER
12. Name John Leonard
13. Birthplace Maryland
14. Maiden Name Mary E. Mitchell
15. Birthplace Maryland

16 (a) Informant Mrs. Anna M. Zegar
(b) Address 2134 Boyd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) JAN 22 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1945, at 130P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/5 1936, to 1/20 1945 and that I last saw h~~i~~m alive on 1/20 1945

Immediate cause of death Nephritis, amyloid — Duration 3 mos.
Due to chronic Bronchitis — 10 yrs.
Due to Tuberculous Spine — 50 yrs.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alessi M. D.
Address 621 Harford Rd Date signed 1/22/45

V8 150

Huntington Williams M.D.

624935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51-A

624985 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hansford Rd.
(c) Hospital or institution: Sydenham Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2711 Hemlock Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thos. Marie McCloskey T. McCloskey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Gerald McCloskey

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) October 29, 1899

8. AGE: Years 45 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Balto.; Md. (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph A. Casey

13. Birthplace Md.

MOTHER 14. Maiden Name Ella V. ?

15. Birthplace Md.

16 (a) Informant Geraldine McCloskey

(b) Address 2711 Hemlock Ave; Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-25-45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Rd.

JAN 22 1945 (b) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22 1945, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/21 1945 to 1/22 1945, and that I last saw her alive on 1/22 1945.

	Duration
Immediate cause of death: Hypostatic Pneumonia	
Due to: Pneumococcal Meningitis	3 Days
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret A. D. Smith M. D.

Address Sydenham Hosp Date signed 1-22

X

G24986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24986 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3210 E.Lombard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3210 E.Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Artie O.Beach

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-0274

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary A.Beach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan.24,1887

8. AGE: Years	Months	Days	If less than one day
57	11	24	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business B.& O. R.R.

FATHER
12. Name Thomas Beach
13. Birthplace Va.

MOTHER
14. Maiden Name Mary A.Forbes
15. Birthplace Va.

16 (a) Informant Mar.Mary A.Beach
(b) Address 3210 E.LOmbard St.

17 (a) Burial (b) Date thereof Jan.22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt.Carmel Cem.
Location Balto.Md.

18 (a) Funeral director Philip Henrig Sons
(b) Address 2024 Orleans St. Balto. 31

19 (a) JAN 22 1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18/45 , at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1. 1944 to Jan. 18 1945. and that I last saw him alive on Jan. 18 1945

Immediate cause of death Pulmonary Hemorrhage — Duration 1/2 hr.

Due to Pulmonary infarct. — 8days.

Due to Carcinoma of Larynx Pulmonary Metasteses. — 6 Mos.

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

29. Signature Ethel B Seingerwald M. D.
Address 613 E North Ave Date signed 1-19-45

624987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

624987
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 816 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 816 Mt. Holly St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE POWELL

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	219-14-2290

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Elizabeth Powell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1875

8. AGE: Years	Months	Days	If less than one day
70	0	9	hr. min.

9. Birthplace Pittsburgh, Pa.
(Town, county, and state)
10. Usual Occupation Salesman & Collector
11. Industry or business Potomac Building Co.

FATHER
12. Name Simpson M. Powell
13. Birthplace Pa.

MOTHER
14. Maiden Name ? Floyd
15. Birthplace Pa.

16 (a) Informant Mrs. Mary Elizabeth Powell
(b) Address 816 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/45 (month) (day) (year)
(c) Cemetery or crematory Bozman Meth. Ch. Cem.
Location Bozman, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 22 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/20 1945, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1944, to 1/20 1945 and that I last saw him alive on JAN. 20 1945

Immediate cause of death	Duration
CORONARY THROMBOSIS	½ HR.
Due to ARTERIOSCLEROTIC HEART DISEASE	1 YR.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert F. Healy M.D.
Address 301 Medical Arts Bldg. Date signed 1/20/45

X

624988

624988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945 D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2768 Fenwick Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2768 Fenwick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET LOUISA GOODWIN

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Walter M. Goodwin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1875

8. AGE: Years 69 | Months 11 | Days 18 | If less than one day hr. min.

9. Birthplace Forest Hill, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wilbur F. Wallis
13. Birthplace Forest Hill, Md.

MOTHER
14. Maiden Name Rose Ida McComas
15. Birthplace Balto., Md.

16 (a) Informant Mr. Preston M. Wallis
(b) Address 2768 Fenwick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/45 (month) (day) (year)
(c) Cemetery or crematory Vernon M. E. Church
Location White Hall, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 193 JAN 22 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19, 1945, at 7:15PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1945 to Jan 19 1945 and that I last saw her alive on Jan 19 1945

Immediate cause of death: Coronary Occlusion — Duration: 3 Dys

Due to: Hypostasis Congestion — 4 Hrs

Due to: Vascular Degeneration

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack J. Kinzer M. D.

Address 2700 Harford Rd Date signed Jan 22 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G24989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G24989 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 Homestead Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balti more
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Homestead Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES FREDERICK NEUNSINGER

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: 705-10-9298

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Barbara C. Neunsinger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 12, 1886

8. AGE: Years 59 | Months 0 | Days 6 | If less than one day hr. min.

9. Birthplace: Hoboken, N. J. (Town, county, and state)

10. Usual Occupation: Police

11. Industry or business: Canton, R.R.

FATHER
12. Name: Charles F. Neunsinger
13. Birthplace: Hoboken, N. J.

MOTHER
14. Maiden Name: Ella O'Connor
15. Birthplace: Staten Island, N.Y.

16 (a) Informant: Mrs. Charles Dubcak
(b) Address: 1702 Homestead Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-45 (month) (day) (year)
(c) Cemetery or crematory: Oaklawn Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave. & Broadway

19 (a) JAN 22 1945 (Date received) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18 1945, at 9.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1944 to June 18 1945, and that I last saw him alive on January 18 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	7 mo.
due to Cerebral Hemorrhage	2 hrs
Due to Arterio Sclerosis	7 mos
Due to Hypertension	7 mos
Other Conditions	7 mos

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F F A Stevens M. D.
Address 2878 Hanford Rd Date signed 1-20 46

VS 150

624990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 81a

624990 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. Ridgewood Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT MAXWELL YOUNG

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 063-09-3656

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ruth Eleanor Robinson
6 (c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): June 4, 1895

8. AGE: Years	Months	Days	If less than one day
49	7	16	hr. ... min

9. Birthplace: Nanticoke, Md. (Town, county, and state)
10. Usual Occupation: Group Dept. Supervisor
11. Industry or business: Metropolitan Life Ins.

FATHER
12. Name: Robert Young
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mary ?
15. Birthplace: Maryland

16 (a) Informant: Mrs. Ruth F. Young
(b) Address: Ridgewood Road, Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-45 (month) (day) (year)
(c) Cemetery or crematory: Moreland Memorial Park
Location: Baltimore, Maryland

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave. & Broadway

19 (a) JAN 22 1945 (Date rec'd by registrar) (b) Huntington Millspaugh, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20 1945, at 9:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/17 1945 to 1/20 1945.
And that I last saw him alive on 1/20 1945.

Immediate cause of death: Wolff-Parkinson-White Syndrome — Duration

Due to: Acute Coronary Occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Harry E. Wallace M. D.
Address: 1400 [illegible] St. Date signed: 1/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

341968 4991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G24991 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 E. 34th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stanley A. Pentz
3 (b) If veteran, name war
3 (c) Social Security Account No. 717-03-1422

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Carrie Pentz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1885

8. AGE: Years	Months	Days	If less than one day
59	7	3	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation druggist
11. Industry or business
FATHER 12. Name John J. Pentz
13. Birthplace Md
MOTHER 14. Maiden Name Ella Rose
15. Birthplace Md
16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 24 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn. Md.
18 (a) Funeral director G. Howard Strong
(b) Address 3707 W. North ave
19 (a) (Date received by Registrar) (b) Huntington Williams, M.D.

JAN 22 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1945 at 8:25 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 1-20 1945 to 1-20 1945 and that I last saw him alive on 1-20 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to pulmonary edema	24 hrs
Due to myocardial infarction	
due to arteriosclerotic heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Abraham Wilson M. D.
Address 1 Wilson Ave Date signed 1-21-45

X

G24992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G24992

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Hayette & Pulaski

(c) Hospital or institution:

Bon Secours

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1830 W. Fayette St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Mr. Edwin Lewis Stewart

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 12 1901

8. AGE: Years 43 Months 9 Days 8 If less than one day ... hr. ... min.

9. Birthplace Benedict. md

(Town, county, and state)

10. Usual Occupation Painter.

11. Industry or business General Painting

FATHER 12. Name James E. Stewart

13. Birthplace Chas. Co md

MOTHER 14. Maiden Name Sarah E. Gourley

15. Birthplace Prince Geos Co Md

16 (a) Informant Mrs. J. Mulvoch

(b) Address 1830 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Old Frederick Rd

18 (a) Funeral director Thos F. Kenny

(b) Address Hollins & Eutaw

19 (a) JAN 22 1945 (b) Huntington Williams M.D. Registrar

(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/20/45 19 ... at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1945 to 1/20 1945 and that I last saw h[illegible] alive on 1/20 1945

Immediate cause of death	Duration
Portal Cirrhosis & Ascites	6 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Portal Cirrhosis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at [redacted]

(e) Means of injury

23. Signature Richard C. Hayden M. D.

Address Bon Secours Hosp Date signed 1/20/45

VS 150

G24993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G24993 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Hilleary & Catons Ave.

(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 95 min

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Howard

(c) City or town Ellicott City, Md. (If outside city or town limits, write RURAL and give town)

(d) Street No. Ellicott City, Md. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Joseph Hunt

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1871

8. AGE: Years 73 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business Retired Farmer

FATHER 12. Name Joseph Hunt

FATHER 13. Birthplace Md

MOTHER 14. Maiden Name Mary Cann

MOTHER 15. Birthplace Md

16 (a) Informant Sarah Hunt.

(b) Address 401 Cathedral St. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-45 (month) (day) (year)

(c) Cemetery or crematory St Johns

Location Ellicott City Md

18 (a) Funeral director J. C. Heinmuhlbrahm

(b) Address Ellicott City Md

19 (a) [illegible] (b) Huntington Williams

JAN 22 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19 1945, at 1:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19-1945 to 1-19-1945, and that I last saw him alive on 1-19-1945.

	Duration
Immediate cause of death: Arteriosclerotic Cardio-Vascular Disease	2 yr.
Due to: Coronary Thrombosis	2 hours.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature George E. Bengtoff M. D.

Address Elliott City, Md Date signed 1-20-45

X

G24994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G24994

Registered No.

1. PLACE OF DEATH: D.S.A.
(a) Baltimore City, Maryland
(b) Street address 1533 N. Eden St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1533 N. Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Jetter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Alice Jetter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 9, 1889

8. AGE- Years 55 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace S. Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Alice Jetter
(b) Address 1533 N. Eden St.

17 (a) Burial (b) Date thereof Jan 23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County

18 (a) Funeral director Mrs. Robert A. Elliott & Wife
(b) Address 1300 E. Baltimore St. Baltimore, Md.

JAN 22 1945

(Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/18 1945, at 9:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Phelps for Tulin, M.D.
Medical Examiner.
Date signed 1/18/45

VS 151

...TE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied as especially important. Physicians: please write the causes of death clearly and legibly.

G24995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G24995 Registered No. 465

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 534 N. Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 534 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lydia Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Married

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1884

8. AGE: Years 60 | Months 9 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Louis Hawkins
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Carter
15. Birthplace Md.

16 (a) Informant William Hawkins
(b) Address 534 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 24 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location C.G. County Md.

18 (a) Funeral director Mrs. Joseph A. Elliott & Bro.
(b) Address 1129 N. Caroline Street

19 (a) (Date received by local registrar) JAN 22 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

1-21-45

20. DATE OF DEATH 1/20 1945, at 3:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/21 1944 to 1/20 1945, and that I last saw h... alive on ... 19...

Immediate cause of death: Carcinuma - stomach — Duration: approx 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rayner Browne

Address 1500 E. Madison St. Date signed M 1 D 20

Rayner Browne X

G24996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 93D

G24996 Registered No.

MARK "X" IN RESERVED FOR RECORDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 N. Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wilson D. Cornish

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Clara Cornish

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12th 1897

8. AGE: Years 47 | Months 7 | Days 18. If less than one day hr. min.

9. Birthplace Taylors Is. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Aaron Cornish
13. Birthplace Taylors Is. Md.

MOTHER 14. Maiden Name Sophia Wilson
15. Birthplace Taylors Is. Md.

16 (a) Informant Mrs. C. Logan Cornish
(b) Address 523. N. Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location Cheery Hill

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) JAN 22 1945 (Date rec'd by registrar) Katie R. Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19, 1945. 5:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4-1945 to 1-19-1945 and that I last saw him alive on 1-16-1945.

Immediate cause of death Cerebral accident — Duration

Due to

Due to

Other Conditions Chronic Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. R. Campbell M. D.
Address 718 Dolphin St. Date signed 1-22-45

X

G24997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 a

Registered No. G24997

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1844 Eagle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1844 Eagle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Lewis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Lillie Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 1st 1888

8. AGE: Years 56 | Months 10 | Days 18 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name ?
13. Birthplace
MOTHER 14. Maiden Name } Unknown.
15. Birthplace

16 (a) Informant Mrs. Lillie Lewis
(b) Address 1844 Eagle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Arbutus - Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 327 N Schroeder St.

19 (a) JAN 22 1945 (Date received by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-19 1945 at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1944 to 1/19 1945 and that I last saw him alive on 1/18/1945

Immediate cause of death | Duration
Aortic Regurgitation 1 yr
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature B. N. Hatcher M. D.
Address 1757 Eutaw Pl. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G24998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 83a G24998

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1708 Eutaw Place

(c) Hospital or institution: Elmhurst Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or town Baltimore (If outside city limits, write RURAL and give town)

(d) Street No. 1708 Eutaw Place (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Elizabeth Fedley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edward C. Fedley

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 8 1869

8. AGE: Years 75 | Months 2 | Days 12 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER: 12. Name Mark Hall

13. Birthplace Balto, Md.

MOTHER: 14. Maiden Name

15. Birthplace Md

16 (a) Informant Walter S. Fedley

(b) Address 514 N. Fedley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23/45 (month) (day) (year)

(c) Cemetery or crematory Forest Park

Location Baltimore, Md

18 (a) Funeral director F. A. Kappert & Son

(b) Address 300 Eutaw Place

19 (a) JAN 22 1945 (Date) rec'd by registrar (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20th 1945 at 6 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15- 1945 to 1-19- 1945 and that I last saw her alive on 1-19- 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to adv. atherosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Louis Sparks M. D.

Address 1700 Eutaw Pl Date signed 1-22-45

VS 150

G24999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G24999

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 833 W Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 833 W Fayette St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine J Harmon

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Charles H Harmon
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 7 1868

8. AGE: Years 76 | Months 8 | Days 23 | If less than one day: hr.

9. Birthplace: Baltimore MD (Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business:

FATHER 12. Name: John Jacob Kroner
13. Birthplace: Germany

MOTHER 14. Maiden Name: Emma Kuppers
15. Birthplace: Germany

16 (a) Informant: Theresa E Dubber Daughter
(b) Address: 833 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 23 - 45 (month) (day) (year)
(c) Cemetery or crematory: Loudenslager
Location: Baltimore MD

18 (a) Funeral director: Mrs John W Fayette Herbert
(b) Address: 801 W Fayette

19 (c) [illegible] Registrar: Huntington Williams M.D. Registrar

JAN 22 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1945 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Jan 21 1945, and that I last saw her alive on Jan 15 1945.

Immediate cause of death: Broached Pneumonia — Duration: 1 week

Due to: Cerebral Sclerosis — Duration: 18 mo

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: no

If death was due to external causes, fill in the following:

Accident, suicide, or homicide:

Date of occurrence: at M

Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature D. L. Kuppers M. D.

Address Wentworth Hospital Date signed 1/24/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

625001 | BALTIMORE CITY HEALTH DEPARTMENT | 625001

CERTIFICATE OF DEATH 471

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in capitals.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 W Rogers Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME J. Harold Rosenblatt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hilda Rosenblatt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-5-87

8. AGE: Years 57 | Months 2 | Days 16 | If less than one day hr. min.

9. Birthplace Wash (Town, county, and state)

10. Usual Occupation Life Insurance Co

11. Industry or business Eggspeting

FATHER 12. Name Sequind Rosenblatt

13. Birthplace Germany.

MOTHER 14. Maiden Name Henrietta Goldsmith

15. Birthplace Germany. Md.

16 (a) Informant Friends.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/45 (month) (day) (year)

(c) Cemetery or crematory Balto. Hebrew

Location Balto. Md.

18 (a) Funeral director Harry Sonnheim & Son

(b) Address 1902 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 100 JAN 22 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-21-1945 at 1:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1945 to 1-21-1945. and that I last saw h[illegible] alive on 1-21-1945.

Immediate cause of death Respiratory failure.

Due to Carcinoma of

Due to right lung, bronchogenic, with

Other Conditions metastases

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Adeno carcinoma 2

of autopsy: Ca of lung, metastatic [illegible]

Duration

PHYSICIAN

Underline the cause to which death should be [illegible]

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ross L. McLean M.D.

Address J. H. H. Date signed 1-24-45

G25002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55

Registered No. G25002

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith
(c) Hospital or institution:
Motherhouse of Notre Dame 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore.
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901. Aisquith St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Sister M. Antonilda Goedke

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14-1905

8. AGE: Years	Months	Days	If less than one day
39	4	7	hr. min.

9. Birthplace Baltimor
(Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business Religious

FATHER
12. Name Aloysius Goedeke
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth Hefner
15. Birthplace Long Green Md.

16 (a) Informant Sr. M. Stan. Kostka
(b) Address 901 Aisquith Street

17 (a) Burial (b) Date thereof Jan. 23rd 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Notch Cliff.
Location Glren Arm.

18 (a) Funeral director Geo. M. Fink & Son.
(b) Address 811. N. Wolfe St.

JAN 22 1945
(Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1945, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1944, to Jan. 21 1945, and that I last saw her alive on Jan. 20 1945.

	Duration
Immediate cause of death Melanotic Carcinoma	
Due to General Metastasis	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation June 1943
Major findings of operation: Pigmented Malignant Melanoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. J. Kirby, M. D.
Address 1102 E. North Ave. Date signed 1/22, 45

G25003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G25003 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2663 Lauretta Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2663 Lauretta Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Max Seboda [Swoboda]

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Male
5. Color or race White
6 (a) ~~Single, married~~, widowed, or divorced. Widowed
6 (b) Name of ~~husband or~~ wife Victoria
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) about 1865
8. AGE: Years 80 | Months 79 | Days | If less than one day hr. min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Paperhanger
11. Industry or business Self

FATHER
12. Name Unknown
13. Birthplace Poland

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Helen Seboda
(b) Address 2663 Lauretta Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.
19 (a) JAN 22 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1945, at 7:20 A M
21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1944, to Jan. 21 1945, and that I last saw h~~im~~er alive on Jan. 14, 1945.

	Duration
Immediate cause of death Acute Cardiac Dilatation	about 3 hrs
Due to Generalized Arteriosclerosis Chronic Myocarditis	?
Due to	
Other Conditions Hypertrophied Prostate	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Philip F. Lerner
Address 2401 W. North Ave Date signed 1/24/45

VS 180

G25004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G25004
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) ~~State~~ Norway ~~County~~
(c) ~~City~~ or town Drammen
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(e) Citizen of foreign country? (If rural give location) Norway (Yes or No)
If yes, name country Norway

3 (a) FULL NAME Svene Hasletad

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Esther
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 6. 1898
8. AGE: Years 46 ~~45~~ 46 | Months 6 | Days 11 | If less than one day hr. min.
9. Birthplace Norway (Town, county, and state)
10. Usual Occupation Ship Steward
11. Industry or business Merchant Marine
FATHER 12. Name Unknown
13. Birthplace ,
MOTHER 14. Maiden Name ,
15. Birthplace ,
16 (a) Informant Norwegian Consul
(b) Address Baltimore Md
17 (a) Disposition Cremation (b) Date thereof 1/23/45 (month) (day) (year)
(burial, cremation, or removal)
(c) Cemetery or crematory Green Mount
Location Baltimore Md
18 (a) Funeral director Williams Funeral Home
(b) Address 1217 E Pratt St
19 (a) JAN 22 1945 (b) Thurston Williams, M.D. Registrar
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1945, at 7 30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 25-6
(a) Date of injury January 17, 1945 7 P M.
(b) Where did injury occur? Maryland Dry Dock
(c) Did injury occur at home, on farm, ~~industrial place~~ in public place? Industrial While at work? Yes
(d) Means of injury Fell from gangplank and Drowned

23. Signature Robert Le Flaten M.D.
Medical Examiner.
Date signed Jan 18 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G25005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G25005 Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4212 Harcourt Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4212 Harcourt Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Richardson Flowers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or~~ wife: Martha Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 6th 1878

8. AGE: Years	Months	Days	If less than one day
66	10	14	hr. min.

9. Birthplace Churchville Md (Town, county, and state)
10. Usual Occupation Asst Supt. Public Schools
11. Industry or business Balto. City

FATHER
12. Name John P. Flowers
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Susie Norrington
15. Birthplace Harford Co. Md.

16 (a) Informant Mrs Mary Kaiser
(b) Address 4212 Harcourt Rd

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 1/23/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) 1945 (Date rec'd by registrar) (b) for Williams M.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20th 1945, at 2.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 1943, to Jan 20 1945, and that I last saw him alive on Jan 20 1945.

Immediate cause of death: Cerebral Apoplexy — Duration: 3 days
Due to: Cerebral Hemorrhage
Due to: Arteriosclerosis & Hypertension — Duration: several years
Due to: Left Side Hemiplegia
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Blue M. D.
Address 1105 E North Ave Date signed 1/24/45

VS 150

~~3412306~~ 625006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 625006

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 6161 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Larsen

3 (b) If veteran, name war: World #2
3 (c) Social Security Account No.: None

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 6 1922

8. AGE: Years: 23 | Months: 0 | Days: 20 | If less than one day: hr. min.

9. Birthplace: N.Y. (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: Erik Larsen
13. Birthplace: Mich.

MOTHER
14. Maiden Name: Margaret Hansen
15. Birthplace: Norway

16 (a) Informant: records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial, cremation, or removal: Burial (b) Date thereof (month) (day) (year): 1/25/45
(c) Cemetery or crematory: Lutheran Mem Gdns
Location: Glen Meyer Md

18 (a) Funeral director: Milhorn & Lee
(b) Address: 1294 Eutaw St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 – 1945, at 1:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10- 1945, to 1-21- 1945, and that I last saw him alive on 1-21- 1945.

Immediate cause of death: Carcinomatosis — Duration:
Due to: Site of origin
Due to: undetermined
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Ross L. McLean M. D.
Address: J. H. H. Date signed: 1-21-45

VS 150

G25007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G25007

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2555 Frederick Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2555 Frederick Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Lina Selma Reinhard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John George Reinhard | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1864

8. AGE: Years 80 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Germany (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name F. Meinhold

13. Birthplace Germany

MOTHER 14. Maiden Name Ernestine Schlutter

15. Birthplace Germany

16 (a) Informant Milda S. Stalberg

(b) Address 2555 Frederick Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-45 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore Md.

18 (a) Funeral director George W. Schwab

(b) Address 2101 Frederick Avenue

19 (a) JAN 23 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1945; at 1:50 P.M

21. I certify that death occurred on the date above stated; that I attended the deceased from 2101 1943 to Jan 20 1945; and that I last saw him alive on Jan 20 1945.

Immediate cause of death Cerebral Hemorrhage and

Due to Cardio Vascular Disease & Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1/14/45
12/44
2 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eliot W. Johnson M. D.

Address 3432 Frederick Ave Date signed

VS 150

G25008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X Y 3D

Registered No. G25008

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Pittsburgh (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 N. Craig Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Cullen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Patrick J

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6 1880

8. AGE: Years	Months	Days	If less than one day
64	6	14	hr. min.

9. Birthplace Pittsburgh Pa. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James La nnigha n
13. Birthplace England

MOTHER
14. Maiden Name Catherine Farrell
15. Birthplace England

16 (a) Informant Hospital Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/ 22/45 (month) (day) (year)
(c) Cemetery or crematory Brownsville Pa.
Location

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

JAN 23 1945 (Date rec'd by registrar) (b) Huntington W. Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22 1945, at 1:37 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 1944, to 1-22 1945 and that I last saw her alive on 1-22 1945.

Immediate cause of death Terminal Pneumonia — Duration

Due to Arteriosclerotic C-V disease & cardiac cirrhosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius Godlove M. D.
Address Md. Gen. Hospital Date signed 1-22-45

Julius X Godlove

G25009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G25009

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR RECORDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3903 Ridgewood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3903 Ridgewood Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter R. Bader

3 (b) If veteran, name war: Wored War #1
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Edna
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) October 26 1893

8. AGE: Years	Months	Days	If less than one day
59	2	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Auditor
11. Industry or business Metropolitan Life

FATHER
12. Name Henry Bader
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Elizabeth Mildner
15. Birthplace Balto. Md.

16 (a) Informant Edna Bader
(b) Address 3903 Ridgewood Ave

17 (a) Burial (b) Date thereof 1-25-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn Cemetery

18 (a) Funeral director Wm. Cook
(b) Address Baltimore, Md.

19 JAN 23 1945
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/21 1945, at 3:15 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury

23. Signature Christo F. Jubinski M.D.
Medical Examiner.
Date signed 1/21/45

Over

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G25010

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3232 E. Lombard st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3232 E. Lombard st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David H. Mumma

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 2086

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or~~ wife: Susie Pew Mumma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29 1861

8. AGE: Years 83 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Building

FATHER
12. Name William Mumma
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. "
15. Birthplace "

16 (a) Informant Mrs. Eva Wolf
(b) Address 3232 E. Lombard St.

17 (a) Burial (b) Date thereof 1-25-45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ M.E. Church
Location York Pa.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (Date received by Registrar) JAN 23 1945 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21st 1945, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20 1945 to 1-21 1945, and that I last saw h alive on 19

Immediate cause of death: Apoplexy — Duration 36 hrs

Due to: Hypertension — Duration years

Due to: Arterio Sclerosis — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Dew M. D.
Address 2901 E. Mon St Date signed 1-22-45

625011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 310

Registered No. 625011

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2512 Barclay st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2512 Barclay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Dietz

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed
6 (b) Name of husband ~~or wife~~: John Dietz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 13th 1859

8. AGE: Years 85 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Home
11. Industry or business —

FATHER
12. Name Rudolph Schroder
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant John R. Dietz
(b) Address 5015 Midwood Rd

17 (a) Burial (b) Date thereof 1/25/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto Md.
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 JAN 23 1945 (Date received by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22nd 1945, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945, to Jan. 22 1945, and that I last saw her alive on Jan 21 1945.

Immediate cause of death: Bronchopneumonia — Duration: 1 week

Due to: arterio sclerotic — Duration: undetermined
cardio vascular renal disease

Due to

Other Conditions: none
(Include pregnancy within 3 months of death)

Date of operation: none
Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. C. Dunnigan M. D.
Address 31 E North Ave Date signed 1/27/45

625012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

V 625012 Registered No.

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct ago is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1739 N Duncan St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret Rose Jones

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Wilmer L
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10 1901

8. AGE: Years 43 | Months 10 | Days 10 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Louis J Staab
13. Birthplace Richmond Va

MOTHER
14. Maiden Name Margaret Normann
15. Birthplace Baltimore Md

16 (a) Informant Catherine McCloskey.
(b) Address 6178 Glover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore Md

18 (a) Funeral director Wilhoms Lodge
(b) Address 1217 E Oval St

19 (a) JAN 23 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1945, at 7½ P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/18 1945 to 1/20 1945 and that I last saw her alive on 1/20 1945.

Immediate cause of death	Duration
9 Intestinal Obstruction	2 days
Due to Strangulated Umbilical Hernia	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hubert G. Wagner M. D.
Address 1105 N Gay St Date signed 1/20/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. the causes of death clearly and legibly.

G25013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

G25013 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2329 Grunmount
(c) Hospital or institution: None
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2329 Grunmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel C McCarty

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Herbert H McCarty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15 1876

8. AGE: Years 69 | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles A Sheridan
13. Birthplace Baltimore Co Md

MOTHER
14. Maiden Name Mary Young
15. Birthplace Baltimore Co Md

16 (a) Informant Anne McCarty
(b) Address 2329 Grunmount Ave

17 (a) Buna (Burial, cremation or removal) (b) Date thereof 1/24/45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director Wilhelm Eck Inc
(b) Address 1217 E Fort Ave

19 JAN 23 1945 (Date City Registrar) (b) Signature for Williams Mc

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1945, at 9 32 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 19 44 to Jan 28 19 45, and that I last saw h alive on Jan 20 19 45

Immediate cause of death: Cardiac insufficiency — Duration

Due to — Apoplexy

Due to Chr Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur C Hemminger M. D.

Address 800 E North Ave Date signed 1/24/45

VS 150

G25014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33A

G25014 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Marshall St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Marshall St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie Heckner

3 (b) If veteran, name war: —
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21. 1854

8. AGE: Years 90 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant John Heckner
(b) Address 1708 Marshall St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Irvington, Md
18 (a) Funeral director Wilhelm Bros
(b) Address 2702 E Pont St
19 JAN 23 1945 (Date rec'd by registrar) (b) Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1945, at 6 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1945 to Jan 21 1945, and that I last saw h[illegible] alive on Jan 20 1945.

Immediate cause of death	Duration
Hypostatic Pneumonia	2 days
Due to Bronchitis Acute	12 days
Due to Influenza	12 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. W. Miller M. D.
Address 1279 William St Date signed 1/24/45

VS 150

For G25015
1440 E Baltimore St

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

G25015
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 806 McHenry Ave
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 806 McHenry Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katharine C Wynn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Robt. S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6 1893

8. AGE: Years 51 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Frederick Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Harry Dyer
13. Birthplace Md

MOTHER 14. Maiden Name Susan Layman
15. Birthplace Md

16 (a) Informant Robt S Wynn
(b) Address 806 McHenry Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Enos A Tyler
(b) Address Fulton & Fayette

19 (a) (b) Huntington Hilliard Md

JAN 23 1945

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1945, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1936, to Jan 21 1945, and that I last saw h alive on Jan 21 1945.

Immediate cause of death	Duration
a Aortic Cardiac Dilatation	
Due to Chronic Myocarditis	
Due to Chronic Valvular disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. C Fulton M. D.
Address 1611 E Baltimore Date signed 1/23/45

X

G25016 V G25016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 W. Ropewalk Lane (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Hail Grice

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	bl	Married

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/22/1894

8. AGE: Years	Months	Days	If less than one day
50 49	-	29	...hr. ...min.

9. Birthplace N C (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business —

FATHER
12. Name Andrew Grice
13. Birthplace N C

MOTHER
14. Maiden Name Martha Randlin
15. Birthplace N C

16 (a) Informant Bertie Grice
(b) Address 604 N. Carey St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/23/45 (month) (day) (year)
(c) Cemetery or crematory Charlotte
Location N C

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) JAN 23 1945 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH January 20 1945, at 1:15 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes, ☐ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Acute Alcoholism

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Bratton M.D.
Medical Examiner.
Date signed 1-20-45

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G25017 ✓ G25017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 538 W West
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs.) mos., or days) 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 538 W West (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Thomas Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Velma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 24, 1901

8. AGE: Years 43 | Months 1 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Pittsburg Pa (Town, county, and state)

10. Usual Occupation Maintance Man

11. Industry or business Kane Transfer Co

FATHER
12. Name James Jackson
13. Birthplace Va

MOTHER
14. Maiden Name Mary ?
15. Birthplace Va

16 (a) Informant Velma Jackson
(b) Address 538 W West St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co Md

18 (a) Funeral director Isaiah L. Brown
(b) Address 108 W Montgomery St

19 (a) JAN 23 1946 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 1946, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 19 46 to 1/19 19 46
and that I last saw her alive on 1/19 19 46

Immediate cause of death	Duration
Cerebral Apoplexy	
Due to Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 7 Bryan Place Date signed 1/23/46

Harrington Williams, M.D.

VS 150

G25018
AB-73682

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 940

G25018
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yr-8mos-15days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 730 S. Bethel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Wagner

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-14-0211

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Delia (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-12-1869

8. AGE: Years 75 | Months 4 | Days 4 | If less than one day ____hr. ____min.

9. Birthplace Mass.
(Town, county, and state)

10. Usual Occupation Old Age Pension

11. Industry or business

FATHER
12. Name Charles Wagner
13. Birthplace Mass.

MOTHER
14. Maiden Name Marie Burger
15. Birthplace Mass.

16 (a) Informant Baltimore City Hospitals (Record)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 1/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Germans Hill Road

18 (a) Funeral director Stat[illegible]
(b) Address [illegible]

19 JAN 23 1945 (b) [illegible] Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16- 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1- 1942, to 1-16- 1945, and that I last saw h im alive on 1-16- 1945.

Immediate cause of death Hypo static Pneumonia and Respiratory Failure — Duration 24 hrs.
Due to Cerebrovascular accident & Coronary occlusion & Nephritis — Duration 48 hrs.
Due to — Duration
Other Conditions — Duration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. J. Penny M.D.
Address B C H Date signed 1-24-45
M. D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

G25019 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Ragnew Gen't Dubland St.

(c) Hospital or institution: West Balto Gen Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 7529 Benalin Rd.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Nancy J. Ferguson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8-1934

8. AGE: Years 10 | Months 5 | Days 14 | Less than one day hr. min.

9. Birthplace Wash. D.C.

(Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER 12. Name Herbert Ferguson

13. Birthplace Virginia

MOTHER 14. Maiden Name Gertrude Jenkins

15. Birthplace Wash. D.C.

16 (a) Informant Herbert Ferguson

(b) Address 7529 Berkshire Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 24-45 (month) (day) (year)

(c) Cemetery or crematory Oak. Lawn

Location Eastern Ave Road.

18 (a) Funeral director John A. Horan

(b) Address 3000 E. Balto St.

19 (a) (Signature of registrar) (b) Huntington Williams, M.D. Registrar

VS 150 JAN 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22 19 44 at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/21 19 44 to 1/22 19 44, and that I last saw h alive on 1/22 19 44.

Immediate cause of death Pulmonary Edema

Due to Rheumatic Heart Dis

Due to Cardiac enlargement & decompensation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Taylor M. D.

Address WB&H Date signed 1/22/44

X

G25020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95 B

G25020 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 Cedarcroft Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 721 Cedarcroft Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lda May Justice

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Wm M Justice Sr
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Dec 20 1903

8. AGE: Years 41 | Months 1 | Days - | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Robt S Richwood
13. Birthplace Baltimore

MOTHER
14. Maiden Name Lotta M Le Brun
15. Birthplace Baltimore

16 (a) Informant Wm M Justice
(b) Address 721 Cedarcroft Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23rd (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Orleans St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150 JAN 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1945, at 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1935 to January 20 1945 and that I last saw her alive on Jan 16 1945

Immediate cause of death Rheumatic Heart disease — Duration 10 years

Due to \

Due to \

Other Conditions \
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: \

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A S Chestnut MD
Address 610 York Rd Date signed Jan 21 1945 M. D.

G25021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46G

Registered No. G25021

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave
(c) Hospital or institution:
Church Home & Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (24)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 Rochester Place
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Mrs. Anna Asaman.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife George Asman (deceased)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13, 1868

8. AGE: Years 76 | Months 3 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Germany.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name not known.
13. Birthplace Germany.

MOTHER
14. Maiden Name Margaret Ardmuth.
15. Birthplace Germany.

16 (a) Informant Geo Asman
(b) Address 105 S Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25 (month) (day) (year)

(c) Cemetery or crematory St Mathews Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Orleans St

19 (a) JAN 23 1945 (Date rec'd by registrar) (b) Huntington Wilson, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1945, at 2:05 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1944, to 1-22 1945, and that I last saw h[illegible] alive on 1-22 1945.

Immediate cause of death Myocardial failure — Duration

Due to Metastatic Ca of lung & generalized carcinomatosis

Due to Carcinoma of the head of the pancreas.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12-19-44

Major findings of operation: Ca of head of pancreas & generalized carcinomatosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James B. Littlefield M. D.
Address Church Home & Hosp. Date signed 1-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be especially important. correct age is

G25022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered G25022

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4909 Arabia Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 86

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 4909 Arabia Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Thomas Harrod

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-14-3917

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1858

8. **AGE:** Years 86 | Months 6 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Butter & Egg Inspector

11. Industry or business Retired Gro-gro

FATHER
12. Name Wm T. Harrod Sr
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary E Spence
15. Birthplace Baltimore

16 (a) Informant Edgar B Harrod Jr
(b) Address 3300 Arlais Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem
Location Woodlawn

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Belvedere Ave

19 (a) JAN 29 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** January 22 1945, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to 1/22 1945, and that I last saw him alive on 1/22 1945.

Immediate cause of death Cerebral Thrombosis
Myocarditis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hyland Polley M. D.
Address 570 Harford Ave Date signed 1/23/45

Huntington Williams, M.D.

Dr Marston 512 Cathedral St Le 7776 ✓

G25023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G25023 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 Benninghaus Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Benninghaus Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rhodon K. Dahl

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife Elizabeth Dahl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27th 1888

8. AGE: Years	Months	Days	If less than one day
56	7	22	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Decorator
11. Industry or business Own Business

FATHER
12. Name Karl T. Dahl
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna Hauer
15. Birthplace "

16 (a) Informant Herman M. Dahl
(b) Address 603 Benninghaus Rd

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1/23/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto Co. Md.

18 (a) Funeral director Wilkinson Cook Inc
(b) Address 1217 St. Paul St.

19 JAN 23 1945 (Date received by registrar) Hettington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19th 1945, at 3.50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1944, to Jan 18 1945, and that I last saw him alive on Jan 18 1945.

Immediate cause of death	Duration
Acute Dilation Heart	few minutes.
Due to Chronic Glomerulo Nephritis	years or longer.
Due to Uraemic Acute with	6 days
Other Conditions Coma.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James Graham Marston M. D.
Address 512 Cathedral St Date signed 1-23-45

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G25024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1172

Registered No. G25024

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 434 N. Arlington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1319 Madison Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Stewart Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1893

8. AGE: Years 51 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Truck driver

11. Industry or business

FATHER
12. Name James B. Roberts
13. Birthplace Maryland

MOTHER
14. Maiden Name Carfe ?
15. Birthplace Maryland

16 (a) Informant Martha E. Roberts
(b) Address 1319 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 23, 1945 (month) (day) (year)
(c) Cemetery or crematory Balto. Natl. Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. George W. Hubbard
(b) Address 1636 Druid Hill Ave.

19 JAN 23 1945 (Date rec'd by registrar) (b) Huntington-Williams Mtr.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/20 1945 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1944 to 1/20 1945 and that I last saw h[illegible] alive on 1/20 1945.

Immediate cause of death Perforating gastric ulcer

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 6 months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph W. Rackley M.D.

Address 426 N. Johns St. Date signed 1/23/45

G25025 6cl

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G25025

MARGIN RESERVED FOR RECORDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Brunt Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Brunt Street
(If rural give location)
(e) Citizen of foreign country? Nat (Yes or No)
If yes, name country

3 (a) FULL NAME Webster Jenifer

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Eliza

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16, 1880

8. AGE: Years 64 Months 4 Days 1 If less than one day hr. min. m.m.

9. Birthplace St. Mary's Co Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Albert Jenifer

(b) Address 1742 N. Bethune St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/1945 (month) (day) (year)

(c) Cemetery or crematory Arbutus

Location Baltimore, Md.

18 (a) Funeral director Wm. Lewis & Sons

(b) Address 1421 Druid Hill Ave.

19 (a) JAN 23 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-19-45 at 10 45 P.M

21. I certify that I took charge of the remains described above, held an Inspection & Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Carcinoma of Stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.

Date signed 1-20-45

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G25026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G25026 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
Since 1/10/45
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town 15 Lindon Avenue, N.Hills, Pa.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 Lindon Ave., N.Hills, Pa.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID BRACHER KENDRICK

3 (b) If veteran, name war	3 (c) Social Security Account No.
–	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/7/1924

8. AGE: Years	Months	Days	If less than one day
20	10	14	hr. min.

9. Birthplace Warrington, Pa.
(Town, county, and state)
10. Usual Occupation Messman
11. Industry or business Merchant Marine

FATHER
12. Name Charles Kendrick
13. Birthplace Pa.

MOTHER
14. Maiden Name Caroline Brown
15. Birthplace Pa.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 1/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fairview Cem.
Location Montgomery Co. Pa.

18 (a) Funeral director Neb. Geo. W. Hoffman
(b) Address 1631 Druid Hill Ave
(b) Huntingtown Williams, Md

JAN 23 1945
(Registrar) Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Jan. 21, 1945, at 1:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10, 1945 to Jan. 21, 1945 and that I last saw him alive on Jan. 21, 1945

Immediate cause of death Bilateral bronchial pneumonia — Duration: Terminal

Due to Acute exfoliative dermitis, cause undetermined. — Since 1/3/45

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None done
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin F. Jones
Benjamin F. Jones M. D.
Address Baltimore, Md. Date signed 1/22/45

VS 150

MS-58188

G25027 QUANDER G25027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No. 3698

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be especially important. correct age is

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1038 Stoupton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) over 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1038 Stoupton Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Letitia Quander (Quander)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife Thomas Quander
6 (c) If alive, give age 84 73

7. Birth date of deceased (mo., day, yr.) July 29 1859

8. AGE: Years	Months	Days	If less than one day
71	5	21	hr. 18 min. 73

9. Birthplace Fairfax Co. Va (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business Own home

FATHER
12. Name Osborn Quander
13. Birthplace Fairfax Co. Va

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Viola Williams
(b) Address 1038 N. Stoupton Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1/23/45 (month) (day) (year)
(c) Cemetery or crematory Fort Belvoir, Va
Location

18 (a) Funeral director Mrs Lew. H. Holland
(b) Address 1631 Druid Hill Ave

19 JAN 23 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-19 1945, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10 1943 to 1-19 1945, and that I last saw her alive on 1-18 1945

Immediate cause of death Nephritis — Duration 2 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M.D.
Address 1029 N. Stricker Date signed 1-22 45

G25028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G25028 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 N. Bentelou
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 801 N. Bentelou St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thelma Katt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Meyer Katt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Hyman —

13. Birthplace Russia

MOTHER 14. Maiden Name Anna —

15. Birthplace Russia

16 (a) Informant Family

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-45 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt. Carmel

Location

18 (a) Funeral director Jos. Leiter Inc

(b) Address 1434 E. Balto. St

19 (a) JAN 23 1945 Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22-45 19 , at 6:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 30 1944, to Jan. 22 1945, and that I last saw her alive on Jan. 22, 1945.

Immediate cause of death: Carcinoma of the esophagus. — Duration: Several years.

Due to

Due to

Other Conditions Cachexia, secondary to carcinoma and metastases.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma of the esophagus.

of autopsy: No autopsy.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jno. G. Boyer Jr. M.D.

Address 11 E. Chase Street Date signed 1.23.45

G25029 | BALTIMORE CITY HEALTH DEPARTMENT | G25029

CERTIFICATE OF DEATH 80B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 Baker
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Corbin Blair

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-9-1906

8. AGE: Years 38 | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name George Corbin
13. Birthplace Va

MOTHER
14. Maiden Name Alice Jones
15. Birthplace Va

16 (a) Informant Louise Henderson
(b) Address 1705 Baker

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location G. & 60

18 (a) Funeral director Sam'l. H. Chase & Son
(b) Address 638 N. Gilmor St.

19 (a) JAN 22 1946 (Date received by Registrar) Huntington Woodbridge, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19, 1946, at 8 50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/31 1945 to 1/19 1946, and that I last saw her alive on 1/19 1946.

Immediate cause of death Encephalitis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. D. Carr, M. D.

Address Provident Hospital Date signed 1/21/46

G25030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

G25030 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3623 Liberty Heights Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) 44 yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3623 Liberty Heights Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mary Pearl Miller.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband or wife John Thomas Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23 1876

8. AGE: Years	Months	Days	If less than one day
69	6	28	hr. min.

9. Birthplace Brunswick Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Home wife

FATHER 12. Name Bailey Seton Hodges.

FATHER 13. Birthplace Ft. Wayne Ind.

MOTHER 14. Maiden Name Mary Elizabeth Potts

MOTHER 15. Birthplace Ft. Wayne Ind.

16 (a) Informant Mrs. Cordelia Pickus

(b) Address 3623 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof January 24 1945 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto. Md.

18 (a) Funeral director Harry R. Annacott

(b) Address 4204 Richwood Ave

JAN 23 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20 1945, at 2:40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 30 1944, to Jan. 20 1945, and that I last saw h-- alive on Jan 20 1945

Immediate cause of death	Duration
Ch. Myocarditis	1yr
Due to Ch. Parenchymatous	
Due to Nephritis	1942
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature James Brown M. D.

Address 1663 W. North Ave. Date signed 1/25/45

G25031 Fr. Robt I. Kuyler

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310 Registered No. G25031

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4406 Kathland Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28

(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4406 Kathland Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** Mrs. Ella M. Meyers (nee Roe)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John H. Meyers

(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Nov. 3rd 1879

8. AGE: Years	Months	Days	If less than one day
65	2	18	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER

12. Name Thomas B. Roe

13. Birthplace Balto. Md.

MOTHER

14. Maiden Name Ellen Youngs

15. Birthplace Do not know

16 (a) Informant Mrs. John H. Meyers

(b) Address 4406 Kathland Ave

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 1/24/45 (month) (day) (year)

(c) Cemetery or crematory Lorraine

Location Balto., Md.

18 (a) Funeral director Geo. Weber & Son

(b) Address 2503 Edmondson Ave

19 JAN 23 1945 (Date filed by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21st 1945, at 10.20 A M

21. I certify that death occurred on the above date, at [illegible] ed deceased from [illegible] and that I last saw [illegible] alive on 1-21 1945 at 10 am

Immediate cause of death Cerebral Hemorrhage Duration Sudden

Due to Arterio Sclerosis ?

Due to Cardio Vascular Renal ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. P. Kuyler M. D.

Address 1310 Eutaw Pl. Date signed 1-23-45

Referred to Medical Examiner

G25032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G25032

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette and John Sts.
(c) Hospital or institution:
Hospital for the Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 95 years

2. USUAL RESIDENCE OF DEACEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 E. 41st Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
Miss Jane Griffith Keys

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1849

8. AGE: Years	Months	Days	If less than one day
95	3	0	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation retired music teacher

11. Industry or business

FATHER
12. Name Joseph Keys.
13. Birthplace Balto.

MOTHER
14. Maiden Name Ruff.
15. Birthplace Balto.

16 (a) Informant Mrs. Lucille Maguire
(b) Address 605 E. 41st Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) Jan. 24 (day) 45 (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Road.

18 (a) Funeral director Wm. J. Hagan
(b) Address 420 Greenmount Ave.

19 (a) JAN 23 1945 (Date rec'd by registrar) Hunter for Williams, M.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1945, at 1:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from January 3, 1945, to January 21, 1945, and that I last saw her alive on January 21, 1945

Immediate cause of death Pneumonia, R.M.L.; hypostatic.
Due to Fracture, inter-trochanteric, left.
Due to
Other Conditions Arteriosclerosis, general.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: Confirms clinical.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident.
(b) Date of occurrence December 24, at 1944 M
(c) Where did injury occur? 605 E. 41st. Street
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home. While at work? No.
(Specify type of place)
(e) Means of injury Slipped & fell on floor at home.

23. Signature Wm. D. Jarrett III M. D.
Address Women's Hospital Date signed 1-24-45

VS 3

for P.J. Lubinski, by Homer S. Mallett, M.D.

G25033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1612

G25033 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 419 Hanover St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Pearl Spriggs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-3-44

8. AGE: Years	Months	Days	If less than one day
	1	18	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Harvey Spriggs
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah Cikman
15. Birthplace Baltimore, Md.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cherry Hill

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) [illegible] (b) [illegible] Registrar

JAN 28 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 1945, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1945 to Jan. 19 1945 and that I last saw her alive on Jan. 19 1945.

Immediate cause of death	Duration
Cardiac decompensation	1 day
Due to Atelectasis.	3 wk.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Russell Whitemore M. D.
Address Johns Hopkins Hospital Date signed 1/29/45

VS 150

G25034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G25034

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2012 Greensberry Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. B. Frank Howell

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ruth Gandy Howell

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1868

8. AGE: Years 76 | Months 2 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace: New Jersey (Town, county, and state)

10. Usual Occupation: Farmer (retired)

11. Industry or business

FATHER
12. Name: Henry M. Howell
13. Birthplace: New Jersey

MOTHER
14. Maiden Name: Lydia Woodruff
15. Birthplace: New Jersey

16 (a) Informant: Mr. J. Carey Taylor
(b) Address: 2012 Greenberry Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/23/45 (month) (day) (year)
(c) Cemetery or crematory
Location: Bridgeton, N. J.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JAN 23 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1945, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1945 to Jan 22 1945, and that I last saw him alive on Jan. 25 1945

Immediate cause of death	Duration
Cardiac Arrest	
RESPIRATORY FAILURE	
Due to Myocardial Infarction	
Due to Arteriosclerotic Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11/16/45

Major findings of operation: Prostatic hypertrophy

of autopsy: (yes)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Willard L Lemmon M. D.
Address Union Memorial Hosp Date signed 1/22/45

VS 150

G25035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

Registered No. G25035

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1812 Harford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Harford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA VIRGINIA BLOOM

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Samuel E. Bloom
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 26, 1879
8. AGE: Years 65 | Months 3 | Days 24 | If less than one day hr. min.
9. Birthplace Catonsville, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Lamley
13. Birthplace Md.

MOTHER
14. Maiden Name -
15. Birthplace

16 (a) Informant Mrs. Samuel E. Bloom
(b) Address 1812 Harford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date rec'd by registrar) JAN 23 1945 Herrington for Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20, 1945 at 2P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944, to Jan 20 1945 and that I last saw alive on Jan 20 1945

Immediate cause of death	Duration
Acute Cardiac Failure	1 day
Due to Cancer of Bowel (Primary)	1 yr.
Due to (Secondary portion)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Israel Rosen M.D. M. D.
Address 2413 E Monument St Date signed 1/22/45

VS 150

G25036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

G25036 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3520 Hilton Rd.

(c) Hospital or institution:

14

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town 1823 Bolton St.
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. WILLIAM PFEIL

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Caroline W. Pfeil

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1862

8. AGE: Years	Months	Days	If less than one day
82	5	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Henry Pfeil
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Stump
15. Birthplace Germany

16 (a) Informant Mrs. Allen E. Pfeil
(b) Address 5603 Norwood Ave.

17 (a) Burial (b) Date thereof 1/23/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 23 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21, 1945, at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1945 to Jan 21 1945, and that I last saw h alive on 19

Immediate cause of death

Cerebral hemorrhage — Duration: 3 days

Due to and paralysis — Duration: ?

Due to advanced arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?

(e) Means of injury

23. Signature Hallan F. Tibbitt M. D.

Address 220 Harrison Blvd Date signed Jan 22/45

X

G25037

YA-91583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G25037

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1743 E. Eager St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Marybelle Bowie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1868

8. AGE: Years	Months	Days	If less than one day
76 ~~77~~ ?	11	7	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER

12. Name George Bowie

13. Birthplace Md.

MOTHER

14. Maiden Name Sarah Pugh

15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/45 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Gay & Palmer North Ave

18 (a) Funeral director Howard N. Blight, Jr.

(b) Address 4914 Belair Road

19 (a) (b) Registrar

(Date received by Local Registrar) JAN 23 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21, 1945 19 , at 5:20M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/13 1945 to 1/21 1945, and that I last saw her alive on 1/21 1945

Immediate cause of death Bronchopneumonia — Duration 3 days

Due to

Due to

Other Conditions Gen. arteriosclerosis — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm Kenneth Smith M. D.

Address Balt. City Hosp Date signed 1/21/45

G25038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G25038

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard + Green

(c) Hospital or institution:

Univ. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 712 Eastern Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Julia Ruley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife John Ruley

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) July 1, 1884

8. AGE: Years	Months	Days	If less than one day: hr.	min.
60	6	18		

9. Birthplace Balto. Midland (Town, county, and state)

10. Usual Occupation Home wife.

11. Industry or business

FATHER 12. Name Conrad Stadlander

13. Birthplace Germany

MOTHER 14. Maiden Name Hilda Fisher

15. Birthplace Germany

16 (a) Informant Mrs. Justine Spencer

(b) Address 7842 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 23/45 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem.

Location Eastern Ave.

18 (a) Funeral director Fred. A. Kramer & Bro.

(b) Address 1216 N. Charles St.

19 (a) (Date received by Local Registrar) (b) Huntington Williams, M.D. Registrar

JAN 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/19/45 19 , at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15/45 19 , to 1/19/45 19 , and that I last saw her alive on 1/18/45 19 .

Immediate cause of death - Coronary Occlusion - heart failure — Duration

Due to Hypertensive Cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J.W. Mentzer D.

Address Univ. Hosp. Date signed 1/19/45

G25039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

G25039 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Rayner Ave + Dukeland St.

(c) Hospital or institution: West Balto. Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 19

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1410 Ramsay St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Frank Mitchel ~~Mitchel~~ (Michl)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 705-05-4433

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Mitchel

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) May 7- 1879

8. AGE: Years 65 | Months 8 | Days 15 | If less than one day: hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business B & O. R.R.

FATHER

12. Name ?

13. Birthplace Bohemia

MOTHER

14. Maiden Name ?

15. Birthplace Bohemia

16 (a) Informant Anna Mitchel

(b) Address 1410 Ramsay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25- 1945 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Location City

18 (a) Funeral director Roth & B. M. Walter

(b) Address Pratt & Stricker Sts

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JAN 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22 1945 at 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/19 1945 to 1/22 1945 and that I last saw him alive on 1/22 1945

Immediate cause of death	Duration
Bronchopneumonia (confluent Rt Lg)	5 days
Due to Acut. C V D.	
Due to auricular fibrillation mild cardiac enlargement & insufficiency	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature D. J. Taylor M.D.

Address WBGH Date signed 1/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25040 BALTIMORE CITY HEALTH DEPARTMENT 93D Registered No. G25040

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town N.Y.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 422 W. 19th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Erik Berglund

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 50 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Sweden
(Town, county, and state)

10. Usual Occupation Seaman, S.S. Ponca City

11. Industry or business Continental Oil Co.

FATHER
12. Name Unknown
13. Birthplace Sweden

MOTHER
14. Maiden Name Unknown
15. Birthplace Sweden

16 (a) Informant Mrs. Stockdale

(b) Address Manager Steamship Co.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/45 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Brooklyn Md
Location Joh. Ritchie Highway

18 (a) Funeral director Mattox & Nutting

(b) Address 3914 S. Hanover St

19 (a) (b)
(Date rec'd by Registrar) JAN 23 1945 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18 - 1945, at 8:20 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 1-22-45

G25041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G25041 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2016 McKean Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2016 McKean Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward R. Cobler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife B. Antoinette Gray

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Aug 11 1884

8. AGE: Years	Months	Days	If less than one day
60	5	11	hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Ship fitter

11. Industry or business

FATHER

12. Name Adam

13. Birthplace Pa.

MOTHER

14. Maiden Name Louisa Conner

15. Birthplace Pa.

16 (a) Informant Mrs. B. Antoinette Cobler

(b) Address 2016 McKean Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/45 (month) (day) (year)

(c) Cemetery or crematory Calvary

Location Altoona, Pa.

18 (a) Funeral director Martin Zahurstone

(b) Address 1827 W. North Ave.

19 (a) (Date received by Registrar) JAN 29 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27/45, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1/45 to Jan 27/45 and that I last saw h alive on Jan 27/45

Immediate cause of death

(a) Bilateral Broncho Pneumonia

Due to (b) Chronic Nephritis

Due to (c) Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 5 days 7 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. C. Houck MD

Address 49 W. Lafayette Ave Date signed Jan 27/45

625042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. 625042

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1821 N. Gay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 N Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Chas. Taylor Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-10-6578

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary E. Taylor
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) June 29 1904

8. AGE: Years 40 | Months 6 | Days 24 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Camp Holabird

FATHER
12. Name William A. Taylor
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Martha Bunce
15. Birthplace Balto Md.

16 (a) Informant Mary E. Taylor
(b) Address 1821 N. Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-25-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location North Ave

18 (a) Funeral director Chas. C. Miller Inc
(b) Address 2425 E. Oliver St

19 (a) (b) Huntingtor Williamsburg, Md
(Delivered to registrar)
JAN 23 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 22 1945 at 11:02 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/22 1944 to 1/22 1945 and that I last saw h[illegible] alive on 1/22 1945

Immediate cause of death Congestive heart failure — Duration of weeks

Due to Hypertensive heart disease — 1 year

Due to Chronic nephritis — 1 year

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mary Baum
Address 1501 4. Wilton Ave. Date signed 1/23/45 M. D.

X

G25043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 61

G25043 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard x Greene
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) One hour
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 East Eager (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES SCHUELER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary E. Schueler
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Oct - 15 - 1876

8. AGE: Years	Months	Days	If less than one day
68	3	4	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired
11. Industry or business Balto City Water Dept

FATHER
12. Name Christian Schueler
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Berger
15. Birthplace Germany

16 (a) Informant Mary E. Schueler
(b) Address 2222 E. Eager St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 - 23 - 45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave

18 (a) Funeral director John C. Miller Inc
(b) Address 2405 E. Baltimore St

19 (a) JAN 20 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19, 1945 at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.
Date signed Jan 20, 1945

93D

VS 151

G25044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G25044

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1107 E. Lexington st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 E. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Wells

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65 64			hr. min.

9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name James Thomas
13. Birthplace D.C.

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Edna S. Chofield
(b) Address 304 Hargrove alley

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23/1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bradbury ave

19 (a) JAN 23 1945 (Date rec'd by registrar) (b) Evington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1945 at 12.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1945 to Jan 21 1945 and that I last saw him alive on Jan 20 1945

Immediate cause of death Cardio Bronchial Pneumonia — Duration

Due to —

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. E. Allen
Address 121 Asquith St Date signed Jan 22 1945

X

G25045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G25045

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood and Greene

(c) Hospital or institution: University Hospital 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balt

(c) City or town Balt
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2619 W. Mulberry St.
(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Mamie Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex fem.

5. Color or race colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife dead

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 4 1893

8. AGE: Years 51 Months 10 Days 11 If less than one day — hr. — min.

9. Birthplace ? Va
(Town, county, and state)

10. Usual Occupation housekeeper

11. Industry or business —

FATHER 12. Name ? Samuel Harris

13. Birthplace Va

MOTHER 14. Maiden Name ? Martha Goss

15. Birthplace Va

16 (a) Informant self ? Martha Gosnel, daughter

(b) Address 620 N Vincent St.

17 (a) Burial (Burial, cremation, or removal) (b) Date of (month) (day) (year) 1-13-45

(c) Cemetery or crematory Mt. Calvary Cemetery

Location Cedar Hill, Md.

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

19 (a) JAN 23 1945 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-12 1945, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-9 1945, to 1-12 1945 and that I last saw her alive on 1-12 1945

Immediate cause of death Toxemia

Due to cellulitis left hand

Due to

Other Conditions diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Kenneth M. Bourne M. D.

Address Uni. Hosp. Balt. Date signed 1-13-45

152

G25046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 C

G25046 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood and Greene Sts

(c) Hospital or institution: University Hospital 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) 4 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 306 Pine St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Robert Simmons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 41 | Months | Days | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Baker

11. Industry or business Koesters Bakery

FATHER 12. Name John Simmons

FATHER 13. Birthplace North Carolina

MOTHER 14. Maiden Name Ruth

MOTHER 15. Birthplace North Carolina

16 (a) Informant Magnolia Royal

(b) Address 528 Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave

19 (a) JAN 23 1945 (Date filed by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 1945, at 7:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from January 6 1945, to January 16 1945, and that I last saw him alive on January 16 1945.

Immediate cause of death Respiratory Failure — Duration

Due to A. V. block

Due to

Other Conditions Rheumatic C.V.D.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Millard T. Trafford Jr. M.D.

Address University Hospital Date signed 1/16/45

VS 150

G25047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G25047

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 Burgundy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 Burgundy (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race Col'd | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26-1888

8. AGE: Years 56 | Months 3 | Days 25 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Davis
13. Birthplace Md

MOTHER
14. Maiden Name Mary Wright
15. Birthplace Md

16 (a) Informant Lena Warren
(b) Address 618 Burgundy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location

18 (a) Funeral director James A Hayes
(b) Address 142 W. Hill St

19 (a) JAN 23 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1945, at 2 40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/17/45 to 1/21/45 and that I last saw h[illegible] alive on 19

Immediate cause of death

Due to Cerebral Hemorrhage 3 Days

Due to Artio Sclerosis 14 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3 Days
14 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 579 N Carrollton Ave Date signed 1/23/45

VS 150

M. D. R. 1268-9

Shepherd

G25048

G25048 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 131 A

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 570 Whitefield Av St. 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Mary Laura Shepherd

(a) Residence: No. 570 Whitefield Av (WHITEFORD AVE.) St., ... Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. Color or Race: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year): Feb. - 1855

7. AGE: Years 89 | Months 11 | Days | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Balto. Md.

FATHER

13. NAME Josiah Shepherd

14. BIRTHPLACE (city or town) (State or country): Balto Md

MOTHER

15. MAIDEN NAME Frances. C

16. BIRTHPLACE (city or town) (State or country): Balto Md

17. INFORMANT Wm Bacon

(Address) 543 Harwood Av

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Olivet Cem. Jan. 24th 1945

19. UNDERTAKER Wm. H. Thoan

(Address) 4201 Greenmount Av.

20. FILED JAN 23 1945 19.....

Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): January 21 1945

22. I HEREBY CERTIFY, That I attended deceased from June 1 1944 to Jan 21 1945

I last saw h alive on Jan 20 1945. Death is said to have occurred on the date stated above, at 3A. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Thrombosis	1944
Chr Interstitial Nephritis	"
Chron Myocarditis	"

Other contributory causes of importance:

Cerebral Hemorrhage	1945

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? .....

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

No If so, specify .....

(Signed) D. W. Bishop M. D.

(Address) 11 E Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

625049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87D

Registered No. 625049

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3702 ST. MARGARET ST.
(c) Hospital or institution: (BROOKLYN)
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 25-7 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3702 St. Margaret St
(If rural give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country

3 (a) FULL NAME ANTHONY R. KURSHESS (KUCHAUSKAS)

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife MARCIANNA M.
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 7-26-1905

8. AGE: Years	Months	Days	If less than one day
39	6	5	✓ hr. ✓ min.

9. Birthplace LANARK, SCOTLAND (Town, county, and state)
10. Usual Occupation CLERK
11. Industry or business WATER DEPT. BALTO. MD.

FATHER
12. Name CHARLES B. KUCHAUSKAS
13. Birthplace LITHUANIA

MOTHER
14. Maiden Name ELIZABETH M. RUTKAUSKAS
15. Birthplace LITHUANIA

16 (a) Informant MARCIANNA M. KURSHESS
(b) Address 3702 ST. MARGARET ST.

17 (a) BURIAL (b) Date thereof 1 25 45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD.

18 (a) Funeral director Charles W. Kuchauskas
(b) Address 637 WASHINGTON BLVD.

19 (a) (b)
Date received by Local Registrar JAN 28 1945 Registrar Arlington to Williamsport

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1945, at 6:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943, to Jan 21 1945, and that I last saw h[illegible] alive on Jan 21 1945.

Immediate cause of death	Duration
congestive heart failure	
Due to acute pneumonia	
Due to	
Other Conditions multiple sclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas W. Kuchauskas M.D.
Address 302 Patapsco Av Date signed 1/22/45 M. D.

G25050 | BALTIMORE CITY HEALTH DEPARTMENT | G25050

CERTIFICATE OF DEATH

Registered No. 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BALTo, MD.
(c) Hospital or institution: West Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) No
(d) Street No. 705 Rosedale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances H. WietHeger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	WiDOW

6 (b) Name of husband or wife LATE HENRY
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) NOVEMBER 19 1866

8. AGE: Years	Months	Days	If less than one day
79	2	2	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name BERNARD A. HIENE
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARY FRIESMAN
15. Birthplace GERMANY

16 (a) Informant MRS. KETTERER
(b) Address 705 ROSEDALE STREET

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 24 1945 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location BALTIMORE, MARYLAND

18 (a) Funeral director Harry H. Shtzke
(b) Address 4101 Edmondson Avenue

19 (a) Date rec'd by registrar JAN 25 1945 (b) Interment or Removal Williams, MD

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/21 19 45 at 6:45 M.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broncho-pneumonia

Due to

Other Conditions Fracture Femur Right Fracture Hip Right
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 1/13 at 4:15 PM M.
(b) Where did injury occur? Front of Home Fracture Hip & Femur
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? Yes
(d) Means of injury Fell in ice sweeping snow

23. Signature Hugh B. Mitchell M.D. Medical Examiner.
Date signed 1/24/45

625051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625051 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 Edgemont St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Hanna

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Robert E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20, 1877

8. AGE: Years	Months	Days	If less than one day
67	5		hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Frederick Schuster

13. Birthplace Germany

MOTHER 14. Maiden Name Gesina Boveens

15. Birthplace Germany

16 (a) Informant Mr Lowin F. Hanna

(b) Address 407 Edgewood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville

18 (a) Funeral director Harry A. Metzler

(b) Address 4016 Edmondson Ave

19 JAN 22 1945 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/20 1945, at 6.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 19 45 to 1/20 19 45, and that I last saw h.e.r. alive on 1/20 19 45.

Immediate cause of death Respiratory failure — Duration

Due to Hypertensive C.V. Disease — Duration

c Decompensation — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Joseph Calvary de Chaumont

Address St Agnes Hospital Date signed 1/20/45 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

5052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G25052

Registered No. 137a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: University Hospital 28

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. Gen'l German Aged People's Home (If rural give location)

(e) Citizen of foreign country? ? (Yes or No) If yes, name country

3 (a) FULL NAME JACOB HAEGI

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Switzerland (Town, County, and state)

10. Usual Occupation Farmer - retired

11. Industry or business

MOTHER / FATHER

12. Name Gottlieb Haegi

13. Birthplace Switzerland

MOTHER

14. Maiden Name Regina Meyer

15. Birthplace Switzerland

16 (a) Informant Patient

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/45 (month) (day) (year)

(c) Cemetery or crematory Western

Location Balto. Md.

18 (a) Funeral director Harry A. Wiltsee

(b) Address 4101 Edmondson Ave

19 JAN 23 1945 (Date Rec'd by Local Reg.) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-21 1945 at 10:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2 1945 to 1-21 1945. and that I last saw h. alive on 1-21 1945.

Immediate cause of death Uremia — Duration

Due to Postoperative Renal Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1-8-45

Major findings of operation: Benign Prostatic Hypertrophy

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm Carl Eisberg III M. D.

Address Univ. Hosp. Date signed 1-21-45

X

G25053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. G25053

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully s... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 Eastern Avenue
(c) Hospital or institution: home 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Eastern Avenue
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME LEE LING

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No. NONE

4. Sex: MALE
5. Color or race: CHINESE
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Marie Chin Lee
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 65 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace California (Town, county, and state)

10. Usual Occupation Laundry
11. Industry or business " "

FATHER
12. Name UNKNOWN
13. Birthplace CHINA

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace CHINA

16 (a) Informant LEE TAI - (COUSIN)
(b) Address 207 W. Mulberry St., City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Windsor Mill Road, Woodlawn, Md.

18 (a) Funeral director Stewart & Mowen Company
(b) Address (W.F.Wooden-Suc.) 108 W.North Av...

19 (a) (Date received) (Registrar) Huntington Williams, M.D.

JAN 25 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/21 1945, at 2.30 p M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 1944, to 1/21 1945. and that I last saw h.im alive on 1/19 1945.

Immediate cause of death: Carcinoma of the lung — Duration 2 (6 mo)
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis J. Kivel M. D.
Address 100 E. 23rd St. Date signed 1/22/45

X

G25054

AB-72991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

113

G25054

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs- 9 mos- 20days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 Bank St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WLADYSLAW Walter Brogosiewski (or Walter Blogorsewski)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29- 1882

8. AGE: Years 62 Months 7 Days 24 If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Oyster Shucker

11. Industry or business

FATHER
12. Name Andy Brogosiewski or Blogorsewski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 24/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1920 Eastern Ave

19 (a) JAN 23 1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22- 1945 at 2 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2- 1942 to 1-22- 1945
and that I last saw him alive on 1-22- 1945.
Immediate cause of death Bronchopneumonia
aorta & occlusion of aorta and renal arteries
Due to
Due to
Other Conditions gen. arteriosclerosis emphysema
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

Duration
7
"

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C E Leary J M.D.
Address City Hosp. Date signed 1/23/45

99

VS 150

625055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625055 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3418 E. Fairmount Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3418 Fairmount Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William M. Stephens

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Sadie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/12/73

8. AGE: Years 71 | Months 9 | Days 8 9 | If less than one day ... hr. ... min.

9. Birthplace: Penna
(Town, county, and state)

10. Usual Occupation: Grocerman

11. Industry or business: FOR SELF

FATHER
12. Name: Allan Stephens
13. Birthplace: Penna

MOTHER
14. Maiden Name: Brooks
15. Birthplace: Penna.

16 (c) Informant: Sadie Stephens, (wife)
(b) Address: 3418 Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/ 24/ 45 (month) (day) (year)

(c) Cemetery or crematory: Parkwood
Location: Taylor Ave.

18 (a) Funeral director: Lilly and Geiler INC.
(b) Address: 403 S Wolfe Street

19 (a) JAN 23 1945 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 21 1945 at 9/30 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/ 8 1942 to 1/21 1945 and that I last saw h... alive on 1/20 1945

Immediate cause of death: Uremia - sclerosis of Kidneys — Heart Disease — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Charles H. Jones M.D.

Address 3216 Eutaw Pl Date signed 1/24/45

Hunting for Affidavit, etc.

VS 130

G25056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G25056

Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4211 Kennison Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4211 Kennison Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth S. Nagle.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married.

6 (b) Name of husband or wife Claude O. Nagle

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Apr. 11, 1897

8. AGE: Years	Months	Days	If less than one day
47	9	11	..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER

12. Name Guilford D. Ridgley

13. Birthplace Md.

MOTHER

14. Maiden Name Martha Sullivan

15. Birthplace Md.

16 (a) Informant Claude O. Nagle

(b) Address 4211 Kennison Ave.

17 (a) Burial. (b) Date thereof Jan 25 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem.

Location Greenmount, Md.

18 (a) Funeral director Jacob Wink's Sons.

(b) Address Manchester, Md.

19 (a) JAN 23 1945 Huntington Hillsville, Md.
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22, 1945, at 10 40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Jan 22 1945, and that I last saw h-r alive on Jan 22 1945.

Immediate cause of death Myocarditis — Duration 2 weeks

Due to Chronic Parenchymatous Nephritis — 10 yrs

Due to —

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation no

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide no

(b) Date of occurrence — at M

(c) Where did injury occur? —
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)

(e) Means of injury

23. Signature Charles J. Wells M. D.

Address 5276 Park Heights Ave Date signed Jan 27 45

G25057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G25057 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 Parkwood Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antonette Szczukowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-13-45

8. AGE: Years	Months	Days	If less than one day
		7	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Anthony Szczukowski
13. Birthplace Missouri

MOTHER
14. Maiden Name Martha Piotrowski
15. Birthplace N.Y.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Glenmore Philadelphia Rd

18 (a) Funeral director John F. Connelly
(b) Address 418 Eastern Ave. - Essex.

19 (a) JAN 22 1945 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Jan-20 1945, at 2.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-19 1945, to Jan-20 1945, and that I last saw her alive on Jan 20 1945

Immediate cause of death	Duration
Cardiac failure	
Due to Congenital heart disease	7 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Russell Huntington Williams M. D.
Address Johns Hopkins Hospital Date signed 1/22/45

Huntington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25058

AB-91564

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G25058
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 S.Charles Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Josephine Welsh (Mary Welsh Wroten Mitlacker)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-4-1889 1883

8. AGE: Years 55 61 | Months 3 4 | Days 17 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard Welsh (D)
13. Birthplace N.Y.

MOTHER
14. Maiden Name Catherine Egan
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) 1-23 1945 (Date received by registrar) (b) Carrington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21- 1945 at 5.38 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12- 1945 to 1-21- 1945 and that I last saw h. or alive on 1-21- 1945.

Immediate cause of death	Duration
Immediate cause of death Irreversible Shock & Atelectasis	
Due Post-operative gastro-intestinal resection	
Due to Bleeding Gastric Ulcer -	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1-17-45 1-19-45

Major findings of operation: Same -

of autopsy: As above

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Butler M. D.
Address City Hosp Date signed 1-21-45

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

MARG RESERVED FOR BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Ur Num G25059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G25059
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Ruxton - 4. - Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. Chesnut Ave.
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME David Pinkney West

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife -------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1945

8. AGE: Years	Months	Days	If less than one day
---	---	---	6 hr. 20 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation --------
11. Industry or business --------

FATHER
12. Name William Pinkney West Jr.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Katherin Louise Rommel
15. Birthplace Baltimore Md.

16 (a) Informant W. Pinkney West
(b) Address Ruxton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/45 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert St.

19 (a) JAN 2 1945 (Date received by registrar) (b) Huntington for Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23-45, at 7:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1AM 1/23 1945 to 1/23 1945 and that I last saw h. alive on 1/23 1945

Immediate cause of death: Congenital Atelectasis — Duration: 6 hr 20 min

Due to: Incomplete development of organs

Due to: Prematurity

Other Conditions: Central placenta previa. C Cesarean Section
(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at.....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Dr. J. L. Stickel M. D.
Address Bon Secours Hosp. Date signed 1/24/45

G25060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G25060

Registered No. 83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 135 W. Lanvale St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Slingluff (Harry Lee Slingluff)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single (Married) Widowed

6 (b) Name of husband or wife Ethel Slingluff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1867

8. AGE: Years	Months	Days	If less than one day
77	4	5	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Lloyd Slingluff
13. Birthplace Md.

MOTHER
14. Maiden Name Effie Banks
15. Birthplace Md.

16 (a) Informant Eliza S. Slingluff Bonner
(b) Address 135 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director H. W. Myers and Son
(b) Address 805 N. Calvert St.

19 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION 25

20. DATE OF DEATH 1/23 1945, at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1945, to 1/23 1945, and that I last saw h/m alive on 1/23 1945

Immediate cause of death Cerebro-vascular Accident — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers M. D.
Address Franklin Sq. Hosp. Date signed 1/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT ✓ G25061 Registered No.

G25061 CERTIFICATE OF DEATH 163M

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-0-A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 501 E. 29th St. Rooms (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Paul H. Gossert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 42 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Lebanon Penn (Town, county, and state)

10. Usual Occupation Sausage Maker

11. Industry or business Eggkeys

FATHER
12. Name John B. Gossert
13. Birthplace Lebanon Penn

MOTHER
14. Maiden Name Stella Bowser
15. Birthplace Lebanon Penn

16 (a) Informant Armon R. Gossert
(b) Address Cedar Run N. J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23-45 (month) (day) (year)

(c) Cemetery or crematory.....
Location Lebanon Penn

18 (a) Funeral director Leo G. Cook
(b) Address 1201-03 N. Patterson Park Ave

(a) JAN 23 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20-1945, at 8:30 P M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Exhaust gas - automobile

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 1-20- at 8:30 P M.
(b) Where did injury occur? Garage, 2901 Greenmount Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Exhaust gas - closed automobile

23. Signature Howard J. Weldeis M.D. Medical Examiner.
Date signed 1-21-45

X

G25062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

Registered No. G25062

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount.
(c) Hospital or institution: Church Home & Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 20.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Lewinsville (If outside city or town limits, write RURAL and give town)
(d) Street No. - (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Bertha Gaither.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Married

6 (b) Name of husband or wife John Gaither.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-12-1881

8. AGE: Years	Months	Days	If less than one day
64	0	11	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Mr John West.
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Butler
15. Birthplace Maryland

16 (a) Informant Dorsey Gaither
(b) Address Mt Airy Md R.F.D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26-1945 (month) (day) (year)
(c) Cemetery or crematory Evergreen Cem
Location Unionville Maryland

18 (a) Funeral director D. D. Shanklin & Sons
(b) Address Union Bridge & New Windsor Md

19 (a) [illegible] 1945 (b) [illegible]
(Date rec'd by registrar) Huntington Williamsport

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1945; at 4 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2 1945, to 1-24 1945, and that I last saw h[illegible] alive on 1-24 1945.

Immediate cause of death	Duration
a Coronary occlusion	
Due to arteriosclerosis	
Due to	
Other Conditions Uterine Carcinoma with metastasis	

(Include pregnancy within 3 months of death)
Date of operation 1-11-45
Major findings of operation: Uterine Carcinoma & metastases to
of autopsy: omentum

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles S. Hatch M.D.
Address Church Home & Hospital M. D.
Date signed 1-24-45

per Leon G. Michell II M.D.

G25063 ✓ G25063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4509 Weitzel Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4509 Weitzel Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna E. Schwartz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Erdman F. Schwartz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8th 1871

8. AGE: Years	Months	Days	If less than one day
73	6	15	hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Christian Richard
13. Birthplace Germany

MOTHER
14. Maiden Name Mary McDonald
15. Birthplace Md.

16 (a) Informant Mrs. Katharine Plock
(b) Address 306 West Bay Ave. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 26 45 (month) (day) (year)
(c) Cemetery or crematory Immanuel Luth.
Location Balto. Md.

18 (a) Funeral director Lansdale Funeral Home
(b) Address 7406 Belair Rd.

19 JAN 24 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23rd 1945 at 3:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1945 to Jan 23 1945, and that I last saw him alive on Jan 22 1945

Immediate cause of death Carcinoma of Intestines — Duration 1 yr

Due to

Due to

Other Condition Carcinoma of Uterus — Duration 3 yrs

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury none

23. Signature T. L. Gorsky M. D.
Address 5106 Harford Rd. Date signed 1-24-45

VS 180

625064 ✓ 625064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2157 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2157 Mt. Holly St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joshua R. Jolly

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary E. Jolly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 29th 1864

8. AGE: Years	Months	Days	If less than one day
80	2	27	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Wm H. Jolly
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret E. McComas
15. Birthplace Md.

16 (a) Informant Wm H. Jolly
(b) Address 4119 Hamilton Ave.

17 (a) Burial (b) Date thereof 1 25-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto. Co. Md.

18 (a) Funeral director Lansdale Funeral Home
(b) Address 7401 Belair Rd.

JAN 24 1945

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23rd 1945, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7- 1945, to Jan 23- 1945, and that I last saw him alive on Jan 22- 1945

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Mitral Stenosis	4 yrs
Due to	
Other Conditions Arterio Sclerosis	10 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed 1/23/45

X

Dr. Kinzey
2700 Harford. G25065.

✓ G25065

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2824 Grindon Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2824 Grindon Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME charles G. Sheldon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Agnes M. Sheldon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-8-1862

8. AGE: Years	Months	Days	If less than one day
82	5	13	hr. min.

9. Birthplace ?
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. William B. Durm, Jr.
(b) Address 2824 Grindon Avenue #14

17 (a) Brual l (Burial, cremation, or removal) (b) Date thereof 1/24/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) (b)
(Date received by registrar)
JAN 24 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21, 1945, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944 to Jan 16 1945, and that I last saw h[illegible] alive on Jan 16 1945.

Immediate cause of death Chronic Myocarditis

	Duration
Due to Cerebral Arteriosclerosis	1 Day
Due to Hypertension Cancer of Scalp	3 mo
Other Conditions	3 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Faith Q Kinzey M. D.
Address 2700 Harford Rd
Date signed Jan 22 '45

625066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

625066 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Rd
(c) Hospital or institution: Snyders Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4d.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2404 Alma Av (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Carrie M. Saunders

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W. Colo	Single

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 13 1872

8. AGE: Years	Months	Days	If less than one day
73	0	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name George W. Saunders
13. Birthplace Maryland

MOTHER
14. Maiden Name Katherine J. Bell
15. Birthplace Md

16 (a) Informant Jesse H. Saunders
(b) Address 2404 Alma Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto Md
18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd
19 (a) (Date rec'd by registrar) JAN 24 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1945 at 2 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 17 1945 to Jan 22 1945, and that I last saw her alive on Jan 21 1945

Immediate cause of death	Duration
Broncho Pneumonia	3d.
Due to Arteriosclerosis Hypertension	6y 6m
Due to Chronic Interstitial Nephritis	5 y.
Other Conditions Arthritis Deformans (Include pregnancy within 3 months of death)	6 —

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Esta Stevens M. D.
Address 2818 Harford Av Date signed 1-23 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G25067 ✓ G25067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 S. Eaton st.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 60
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 S. Eaton (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Waclauske

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband~~ or wife agnes
6 (c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) 1871 ?

8. AGE: Years	Months	Days	If less than one day
73 ?			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name unknown.
13. Birthplace unknown.

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Joseph Waclauske
(b) Address 603 S. Eaton st

17 (a) Burial (b) Date thereof 1-25-45
*(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore Md

18 (a) Funeral director George R. Weber
(b) Address 705 S. Ann st

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

JAN 24 1945
Vs 110

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22nd 1945, at 4.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1945 to Jan 22 1945, and that I last saw him alive on Jan 22 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. J. Davidow M. D.
Address 3218 Eastern av Date signed 1-23-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1 0 8

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 S. Chapel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Pytrykow

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-12-2746

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Helen IRENE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1880

8. AGE: Years 64 | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Paul
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-45 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md.

18 (a) Funeral director George A. Weber
(b) Address 705 S. Linn st

19 (a) (Date received by registrar) (b) Registrar

JAN 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 1945, at 10:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19 1945, to 1-22 1945, and that I last saw h[illegible] alive on 1-22 1945

Immediate cause of death lobar pneumonia — Duration 1-2 wks?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Perez J. M. D.
Address City Hosp. Date signed 1-25-45

G25069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

G25069 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 561 Laurens St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Kellam

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-22-6923

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Estelle Kellam

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28-1902

8. AGE: Years 42 | Months 0 | Days 23 | If less than one day hr. min.

9. Birthplace Virginia (County and State)

10. Usual Occupation [redacted] Laborer

11. Industry or business

FATHER
12. Name Elery Kellom
13. Birthplace Virginia

MOTHER
14. Maiden Name Rachel Romox
15. Birthplace Virginia

16 (a) Informant Susie Wife (sister)
(b) Address 561 Laurens St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 24 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Arbutus, Balto Co. Md.

18 (a) Funeral director John M. Johnson
(b) Address 1700 Druid Hill Ave

19 JAN 24 1945 (Filing date) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1945, at 11:38 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 2 1945 to January 20 1945 and that I last saw h.i.m. alive on January 20 1945.

Immediate cause of death Respiratory Failure

Due to Luetic C.V.D

Due to

Other Conditions Cirrhosis of Liver

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Luetic CVD Liver cirrhosis

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Millard T. Tyglond Jr. M. D.
Address University Hospital Date signed 1/21/45

124 B

G25070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G25070

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital - DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 Thames St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. FULL NAME ~~Franklin A. Cowen~~ Frank Cowen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
M	W	Widowed

6 (b) Name of ~~husband or~~ wife Lillian Cowen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 14th 1876

8. AGE: Years	Months	Days	If less than one day
~~93~~ 68	10	18	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Nurse, Retired

11. Industry or business —

FATHER
12. Name William L. Cowen
13. Birthplace New Jersey

MOTHER
14. Maiden Name Mary M. Eaton
15. Birthplace Easton Md.

16 (a) Informant Naomi R. Hunt
(b) Address 343 E. Fairmount Ave.

17 (a) Burial (b) Date thereof 1/26/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Woodlawn
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 317 St. Paul St

19 (a) 1/24/45 (b) [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22 1945, at 11:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy - Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Hypertensive Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Charles J. Pickrell M.D.
Medical Examiner.
Date signed 1/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

JL - 91713
G25071

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 108

G25071

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: John McMann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1902

8. AGE: Years 42 | Months 3 5 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace N. Y.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John (D)
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Marryes
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location L. L. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 E. Pratt St

19 (a) 1-24-45 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21 1945, at 2.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 20 1945, to Jan. 21 1945, and that I last saw h. im alive on Jan. 21 1945.

Immediate cause of death: Lobar pneumonia bilateral — Duration 2 wks.
Due to
Due to
Other Conditions: Acute endocarditis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto City Hosp Date signed 1/22/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25072 BALTIMORE CITY HEALTH DEPARTMENT 940 G25072
CERTIFICATE OF DEATH
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 525 Gorsuch ave.
(c) Hospital or institution: 9.5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 525 Gorsuch ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Christie (George G. Christie)

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married,~~ widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Bertha A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17th 189[illegible]

8. AGE: Years	Months	Days	If less than one day
53 5[illegible]	9	5	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Assembly Line
11. Industry or business Hosiery Factory

MOTHER FATHER
12. Name Thilhorn Christie
13. Birthplace England
14. Maiden Name Isabel Galloway
15. Birthplace Bald Md

16 (a) Informant Mrs Anna Lokin
(b) Address 6020 Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/45 (month) (day) (year)
(c) Cemetery or crematory Oakmont
Location Parkville Md

18 (a) Funeral director Thilhorn Corbin
(b) Address 1217 E Fort Ave

19 (a) 1-24-45 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22- 1945 at 7 45 P. M

21. I certify that I took charge of the remains described above, held an Inspection + Inquest Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Maldeis M.D. Medical Examiner.
Date signed 1-23-45

VS 151

G25073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G25073 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 Abbott Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Blaney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ wife Fannie Blaney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12th 1867

8. AGE: Years 77 | Months 5 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Grave Digger

11. Industry or business Green Mount Cemetery

FATHER
12. Name Martin Blaney
13. Birthplace Md.

MOTHER
14. Maiden Name Jane (Unknown)
15. Birthplace Md.

16 (a) Informant Mrs Fannie Blaney
(b) Address 1008 Abbot Court

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1/25/45 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) 1-24-45 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 1945, at 1:15 P. M

21. I certify that I took charge of the remains described above, held an Inspection of the body thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Waldeis M.D.
Medical Examiner.
Date signed January 25, 1945.

G25074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. G25074

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Roomer.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Market Place (Hotel)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl J. Dawson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 45 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Pitt Co. N. C.
(Town, county, and state)

10. Usual Occupation Merchant Marine

11. Industry or business

FATHER
12. Name J. P. Dawson
13. Birthplace Pitt Co. N. C.

MOTHER
14. Maiden Name Alberta Dawson
15. Birthplace Lenoir Co. N. C.

16 (a) Informant: M. S. Smith
(b) Address 206 E. Washington Kinston NC

17 (a) Burial, cremation, or removal Burial (b) Date thereof 1-24-45
(month) (day) (year)

(c) Cemetery or crematory Dawson Cem.
Location Pitt Co. N. C.

18 (a) Funeral director Wilson & Cone
(b) Address 127 E. Cont. St.

19 (a) 1-24-45 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22-1945, at 9 a. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to 2nd & 3rd degree burns

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 4/1

(a) Date of injury 1-22- at 9 a. M.
(b) Where did injury occur? 1618 Market Place
(c) Did injury occur at home, on farm, industrial place, in public place? Public (Hotel) While at work? No
(d) Means of injury: Smoking cigaret, set fire to mattress

23. Signature Howard J. Wallace M.D.
Medical Examiner.
Date signed 1-22-45

G25075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

109

Registered No. G25075

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 780 McHenry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joann Lorenz — JOANN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-16-94

8. AGE: Years | Months: 5 | Days: 6 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Lorenz.
13. Birthplace Md.

MOTHER 14. Maiden Name LaVerne Fenwick
15. Birthplace Solomon Islands

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-24-45 (month) (day) (year)
(c) Cemetery or crematory Holy Stanislaus
Location Rundall ave

18 (a) Funeral director John J. Feeney
(b) Address 2809 Hudson st

19 (a) JAN 24 1945 (Date rec'd by registrar) (b) Waiting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22 1945, at 1'5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20 1945, to 1-22 1945, and that I last saw h[illegible] alive on 1-22 1945.

Immediate cause of death: Respiratory failure
Due to: Pneumonia
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: Pneumonia

Duration: 4 days / 1

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ruth Holdemir M. D.
Address John Hopkins Hospital Date signed 1-24-45

VS 150

625076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 625076

1. PLACE OF DEATH: 539 Dolphin St
(a) Baltimore City, Maryland
(b) Street address 539 Dolphin St
(c) Hospital or Institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 539 Dolphin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Mc Daniel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race col | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Horace M c Daniel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1880

8. AGE: Years 64 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Lowes County (Town, county, state or nation)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Wilson Miller
13. Birthplace Va.

MOTHER 14. Maiden Name Mary C. Saunders
15. Birthplace Va.

16 (a) Informant Horace McDaniel
(b) Address 539 Dolphin St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 1-24-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location Baltimore Md.

18 (a) Funeral director Archibald A. Geddis
(b) Address 2101 McCulloh St.

19 (a) (Date received by registrar) (b) Registrar Huntington Williams M.D.

JAN 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1945, at 1120 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944, to Jan 21 1945, and that I last saw him alive on Jan 21 1945

Duration
7 mos

Immediate cause of death Cardiac - Renal Disease
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2529 Georgia Ave Date signed Jan 24 1945

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Spec.—9-39—A. & Co.—250 Blks.

Dr Adams 23rd St V 625077

625077 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 131a

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 McElderry St ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sattie Fleet

(a) RESIDENCE NO. 1422 McElderry ST. ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life How Long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced, (write the word)
F.	Col.	Widow

6 If married, widowed, or divorced, HUSBAND of (or) WIFE of Andrew Fleet

6 DATE OF BIRTH (month, day, and year) Aug 6 -

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
68	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co, Md

PARENTS

10 NAME OF FATHER Tashman Hebb

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Margrate Wise

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co. Md

14 Informant Bertina Fleet
(Address) 1439 Baulkin St

15 JAN 24 1945 Thos. J. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/21/45

17

I HEREBY CERTIFY, That I attended deceased from Jan 16, 1945, to Jan 21, 1945

that I last saw h... alive on Jan 20, 1945

and that death occurred, on the date stated above, at. 8:45 ... m.

The CAUSE OF DEATH* was as follows:

Hyper cardiac Renal disease

(duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY ..... (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Maurice Adams M. D.

19 (Address) 312 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.) 4/28

19 PLACE OF BURIAL, CREMATION OR REMOVAL Peter B Williams 1875 | DATE OF BURIAL McElderry 1-25-45

20 UNDERTAKER ... | ADDRESS ...

Wm Cahoon Funeral Home 1-24-45

information should be ... ally su... ed. AGE should be ... CAUSE OF DEATH in plain terms, so that it may be pro... properly classified. Exact statement of ... TION is very important. See instructions on back of certi... certificates.

G25078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G25078

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert Streets
(c) Hospital or institution: The Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos, 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1319 Morling Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Frederick Mathews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 17, 1944

8. AGE: Years —; Months 3; Days 6; If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Myron Mathews
13. Birthplace Virginia

MOTHER
14. Maiden Name Kathryn Brown
15. Birthplace Pennsylvania

16 (a) Informant Mrs Kathryn Mathews
(b) Address 1319 Morling Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-25-45 (month) (day) (year)
(c) Cemetery or crematory St Mary's Cemetery
Location Baltimore Md

18 (a) Funeral director Frank Wentz
(b) Address 814 N 36th St

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

JAN 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23, 1945, at 12:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from January 21, 1945, to January 23, 1945, and that I last saw him alive on January 23, 1945.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Acidosis	2 days
Due to Bronchopneumonia (Right upper lobe + left lower lobe)	3 days
Other Conditions Otitis media (Bilateral)	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Doppler, III

Address Union Memorial Hospital Date signed 1/23/45 M

G25079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G25079 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 716 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Richard J. Canby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1944

8. AGE: Years	Months	Days	If less than one day
	5	12	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Pearce J. Canby
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine Whittemore
15. Birthplace Baltimore

16 (a) Informant Mrs. Pearce Canby
(b) Address 716 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 25 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) JAN 24 1945 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22 1945, at 945 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20 1945 to 1-22 1945, and that I last saw him alive on 1-22 1945.

Immediate cause of death: Lobar Pneumonia (Bilateral)

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St Josephs Hosp. Date signed 1-22-45

VS 150

G25080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/86B

Registered No. G25080

Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Orchard St
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Daniel Oglesby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE:	Years	Months	Days	If less than one day
	30			..... hr. ..... min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charles Oglesby
13. Birthplace S. C.

MOTHER
14. Maiden Name Laura ?
15. Birthplace S. C.

16 (a) Informant Mrs. Laura Oglesby
(b) Address 508 Orchard St.

17 (a) Burial (b) Date thereof 1-24-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory.....
Location Seneca, S. C.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) Date received (b) Registrar

JAN 24 1945 Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21 1945 at 3:00 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest

.....

.....

Due to.....

.....

Other Conditions.....

.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury January 21, 1945 24/1 P.M.

(b) Where did injury occur? Liberty Shipyard

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes

(d) Means of injury Steel trusses fell on him

23. Signature Robert L. Bratton M.D.
Medical Examiner.

Date signed 1-22-45

X

G25081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G25081 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address 2123 Division St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 Division St (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Verdell B. Makell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Margaret

6 (c) If alien, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1902

8. AGE: Years 42 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name Joseph Makell

13. Birthplace Balto Md

MOTHER 14. Maiden Name Bertha Houston

15. Birthplace Baltimore Md

16 (a) Informant Blanche Thomas

(b) Address 2029 Bruce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 24, 1945 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk

Location Balto Co Md.

18 (a) Funeral director Wm. Lee & Howland

(b) Address 1631 Druid Hill Ave.

19 (a) (b) Registration District Huntington Williams, M.D.

JAN 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1945, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1945, to Jan 21 1945, and that I last saw him alive on Jan 20 1945.

Immediate cause of death Cardio Vascular Renal Disease — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Frey M. D.

Address 1928 Pa Ave Date signed 1/24/45

G25082

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G25082 Registered No. 120a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Sarah Ann Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME William Wooden

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Widower

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 24 1899

8. AGE: Years	Months	Days	If less than one day
45	11	26	..... hr. ..... min.

9. Birthplace Chase City - Va
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Hope Wooden
13. Birthplace Chase City - Va

MOTHER
14. Maiden Name Rosie Terry
15. Birthplace Chase City - Va.

16 (a) Informant Mrs. Roberta B. Barr
(b) Address 7 Paradise Ave. - Catonsville

17 (a) Burial (b) Date thereof 1-24-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 3221 Edmondson Ave

19 (a) Date received by Local Registrar JAN 24 1945 Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20-1945 at 1.30 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Gastroenteritis

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Maddox M.D.
Medical Examiner.
Date signed 1-20-45

X

G25083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G25083 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 Willow Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523 Willow Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert D. Merryman

3 (b) If veteran, name war: W.W. I
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Alma Abel Merryman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-21-1893

8. AGE: Years 51 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Oil burner service

11. Industry or business

FATHER
12. Name Merryman
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecka Riley
15. Birthplace Maryland

16 (a) Informant Wilma J. Merryman
(b) Address 523 Willow Ave

17 (a) Burial (b) Date thereof 1-25-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Old Mill Cem.
Location Frederick Ave

18 (a) Funeral director A. Lee Ader
(b) Address 4644 York Road.

19 (a) (b)
(Date received by registrar) Registrar

JAN 24 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22 1945, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944, to Jan 20 1945, and that I last saw h-- alive on Jan 20 1945.

Immediate cause of death: Tuberculosis Lungs.
Duration: 2 years

Due to: -

Due to: -

Other Conditions: -

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Strickler M. D.
Address 632 Forrest Ave Date signed Jan 24 1945

X

G25084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G25084 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2310 Annapolis Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. City
(c) City or town Mt. Winans (If outside city or town limits, write RURAL and give town)
(d) Street No. 2310 Annapolis Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sherman Asa Ivey Brooks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Bessie Brooks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26 1906

8. AGE: Years 38 | Months 6 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Pink Hill N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business Laborer

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Bessie Brooks
(b) Address 2310 Annapolis Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Catonsville

18 (a) Funeral director Leonard M. Thompson
(b) Address 638 N. Eutaw St

JAN 24 1945 (Date rec'd by registrar) (By) Huntington Williams M.D. Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22 1945 at 12:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1944 to Jan 22 1945, and that I last saw him alive on Jan 21 1945

Immediate cause of death: Lobar Pneumonia (unresolved) — Duration: 26 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John W. Goings M.D.
Address 6605 W. Baltimore Date signed 1/24/45

G25085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G25085

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write, the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2753 Alameda Blvd.
(c) Hospital or institution:

9-10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2753 Alameda Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY LAFAYETTE ARMSTRONG

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-07-8461

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth Brown

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1874

8. AGE: Years 70 | Months 2 | Days 0 | If less than one day ____hr. ____min.

9. Birthplace Wilmington, Del (Town, county, and state)

10. Usual Occupation Supt. of Filing & Billing

11. Industry or business U.S.F.G.

FATHER
12. Name James Ellwood Armstrong
13. Birthplace Phila. Pa.

MOTHER
14. Maiden Name Harriette Winchester
15. Birthplace Perryville, md.

16 (a) Informant Mrs. Elizabeth Armstrong
(b) Address 2753 Alameda Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-45 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) (Date received by Local Registrar) JAN 24 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22 1945 2:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2-1945 to 1-22-1945 and that I last saw h~~e~~alive on 1-21-1945

Immediate cause of death Uremia — Duration 3 days
Due to Chronic nephritis — Duration Unknown
Due to Arteriosclerosis — Duration Unknown
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. B. Seybert M.D.
Address 280 X Harford Rd Date signed 1-22-45

G25086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G25086 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert st.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) III
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County Balto Co.
(c) City or town Baltimore - 31
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 Bank st
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Herman

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: John H. Herman

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) April 14, 1869

8. AGE: Years 75 | Months 9 | Days 9 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: SABASTIAN SEITER
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: ? Rosch
15. Birthplace: Germany

16 (a) Informant: Mrs. Margaret Dowe
(b) Address: 3800 Northern Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-45 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave. & Broadway

19 (a) (Date) JAN 24 1945 (Registrar) Henry L. Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23-45 19 , at 5 43 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21 1945 to 1-23 1945, and that I last saw her alive on 1-23 1945

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Intracerebral Hemorrhage Cerebral in type	
Due to Essential Hypertension	
Other Conditions Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melchizah Fraguier M.D.
Address UMH Date signed 1-23-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G25087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G25087

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1017 Linden Ave.
(c) Hospital or institution: 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) No.
If yes, name country

3 (a) FULL NAME Lea R. Mills

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Edward J. Mills
13. Birthplace Harrisburg Pa.

MOTHER
14. Maiden Name Clara Gilfoman
15. Birthplace ?

16 (a) Informant Norman Mills
(b) Address 1017 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Sharp St Ext.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) Huntington Williams M.D. (Date received by Registrar) Registrar

JAN 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20. 1945 at 9. P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1945 to Jan 20 1945 and that I last saw h[illegible] alive on Jan 20 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	5 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul A. Johnson M. D.
Address 2329 Eutaw St Date signed Jan 24 1945

G25088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G25088

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City Maryland
(b) Street address 505 Orchard Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimor
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Orchard Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE R. BENSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1879

8. AGE: Years 65 | Months | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Bertina McGowan

(b) Address 915 Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 26, 1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Sharp Street.

18 (a) Funeral director A. J. Halstead

(b) Address 918 Druid Hillave.

19 (a) JAN 21 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21, 1945, at 12:40 P. M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions Uncle edema

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed January 22, 1945

X

VS 151

G25089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G25089 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 51 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 752 W. FAYETTE STREET
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Russell H. Hastings

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/30/1877

8. AGE: Years	Months	Days	If less than one day
67	2	20	hr. min.

9. Birthplace Willoughby, Ohio
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John S. Hastings
13. Birthplace Mass.

MOTHER
14. Maiden Name Kezia Woolsey
15. Birthplace Ohio

16 (a) Informant Mr. Benj. Hastings, brother
(b) Address 3707 - 38th Ave., Cottage City, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/24/45 (month) (day) (year)

(c) Cemetery or crematory
Location Willoughby, Ohio

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received by registrar JAN 24 1945 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20 1945, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1945 to Jan 20 1945, and that I last saw him alive on Jan 20 19 45.

Immediate cause of death Resp. failure — Duration

Due to Toxemia

Due to 3rd Degree Burns

Other Conditions Anemia

(Include pregnancy within 3 months of death)

Date of operation No

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 4/2
(a) Accident, suicide, or homicide Accident.
(b) Date of occurrence 12-1-44 at 9A. M
(c) Where did injury occur? 752 W. FAYETTE STREET (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME. While at work? NO (Specify type of place)
(e) Means of injury BACKED UP AGAINST STOVE & CLOTHING CAUGHT FIRE.

23. Signature Chas. E. Catuit M. D.
Address Redwood & Greene Sts Date signed 1/20/45

For R. J. R. Davis, by Harold J. Meranis M.D. X

G25090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G25090

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Especially important.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 500 S. Ann Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 500 S. Ann Street (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** JOSEPH RESNER (REZNER)

3 (b) If veteran, name war ------

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 65 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Gniezno, Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace

MOTHER

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs. Mary Resner

(b) Address 500 S. Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/45 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location German Hill Road

18 (a) Funeral director M. J. Sadowski & Sons

(b) Address 1808 Eastern Ave.

19 (a) JAN 24 1945 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21 1945 at 3.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1944 to Jan. 21 1945 and that I last saw h-- alive on Jan. 21 1945

Immediate cause of death: Cerebral Hemorrhage

Duration: days

Due to: Chronic Myocarditis

Due to: Chronic nephritis

Duration: 7

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Isaac J. Douglas M. D.

Address 1007 E. Fayette Date signed 1/24/45

VS 150

625091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625091 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 423 Myrtle Ave. - Dist
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 Myrtle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Garland

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife CARL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1-1907

8. AGE: Years 36 | Months | Days 21 | If less than one day hr. min.

9. Birthplace VIRGINIA (Town, county, and state)

10. Usual Occupation HOUSE WORK

11. Industry or business

FATHER
12. Name THOMAS BATTLE
13. Birthplace N.C.

MOTHER
14. Maiden Name EMMA BLUE
15. Birthplace N.C.

16 (a) Informant EARL GARLAND
(b) Address 423 MYRTLE AVENUE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-26-45 (month) (day) (year)
(c) Cemetery or crematory MT. AUBURN
Location BALTIMIRE, MARYLAND

18 (a) Funeral director WILLIAM A. JACKSON
(b) Address 916 PENNSYLVANIA AVENUE

19 (a) JAN 24 1945 (Date Accepted by Registrar) (b) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23 1945, at 8:42 A.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Hypertensive C.V disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury

23. Signature C. J. Tubman Medical Examiner, M.D.
Date signed 1-24-45

G25092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1 81

Registered No. G25092

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 123 Light St.
(c) Hospital or institution: South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 Warren St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Weyman E. Jenkins Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/11/1924

8. AGE: Years	Months	Days	If less than one day
10	1	9	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Weyman E Jenkins Jr
13. Birthplace Pa

MOTHER
14. Maiden Name Ida Geffen
15. Birthplace N. C.

16 (a) Informant Flossie Thompson
(b) Address 936 Warren St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.B.C. Md

18 (a) Funeral director Sarah L Brown Sons
(b) Address 1084 W Montgomery Street

19 (a) (Date rec'd) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - [redacted] 20 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24 1944 to 1-19 1945, and that I last saw h[redacted] alive on 1-20 1945.

Immediate cause of death	Duration
Toxemia	
Due to 2nd & 3rd degree burns	
Due to Stove	
Other Conditions Gas gangrene, tetanus (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide Accident 21/1
(b) Date of occurrence 12-24-44 at M
(c) Where did injury occur? Baltimore, Maryland (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? —
(Specify type of place)
(e) Means of injury Coal oil stove

23. Signature Joseph S. Arduengo M.D.
Address 1215 Light St. Date signed 1-20-45

Affidavit by Thomas J. Madden M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G25093 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4110 Roland Avenue

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4110 Roland Avenue (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Alice Hood Bullard

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Steward B. Bullard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14-1875

8. AGE: Years 69 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Charles F. Hood

13. Birthplace

MOTHER 14. Maiden Name Georgia Coff

15. Birthplace Harpers Ferry, W. Va.

16 (a) Informant Steward B. Bullard

(b) Address 4110 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 25-1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 (a) [illegible] (Date received by registrar) (b) Huntington Williams, M.D. Registrar

JAN 27 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23-1945, at 12-08 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1942, to Jan 23 1945, and that I last saw h~~e~~ alive on Jan 23 1945.

Immediate cause of death Myocardial failure — Duration 7 dy

Due to Arteriosclerotic cardiac disease — Duration 2

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury —

23. Signature [illegible] M. D.

Address 3429 Chantilly Rd Date signed 1/23/45

VS 190

X

625094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 625094

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully entered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1905 Frederick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Louis Reuter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Sophia Reuter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6th 1855

8. AGE: Years	Months	Days	If less than one day
89	9	16	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired Farmer
11. Industry or business Self

FATHER
12. Name Balzer Reuter
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Ann Schenckel
15. Birthplace Germany

16 (a) Informant Mrs Alfred Berry
(b) Address 1705 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-25-45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1617 St Paul St

19 (a) JAN 24 1945 (Date rec'd by Registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22nd 1945 at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945 to Jan 22 1945 and that I last saw ~~him~~ her alive on Jan 21 1945.

Immediate cause of death Myocardial Infarct — Duration 3 Wks
Due to
Due to
Other Conditions General Arteriosclerosis ?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 336 Fredericks Ave Date signed

VS 150

G25095

HEALTH DEPARTMENT—CITY OF BALTIMORE

G25095

CERTIFICATE OF DEATH

1. PLACE OF DEATH Bel. Gf. Amer. Hosp. ✓ 160a — Registered No.

CITY OF BALTIMORE: (No. 418 W. Lexington St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

If U. S. Veteran specify WAR

2. FULL NAME Infant McLean

(a) Residence: No. 605 W. Saratoga St., Ward. (Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Jan 20, 1945

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		✓ 3	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Balto (State or country) Md

FATHER

13. NAME Jas. McLean

14. BIRTHPLACE (city or town) Sylvia (State or country) N.C.

MOTHER

15. MAIDEN NAME Ida Bryson

16. BIRTHPLACE (city or town) Dawsville (State or country) N.C.

17. INFORMANT

(Address)

18. BURIAL, CREMATION, OR REMOVAL

Place [illegible] JAN 24 1945, 19

19. UNDERTAKER Commissioner of Health

(Address)

20. JAN 24 1945 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan 23, 1945

22. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1945, to Jan 23, 1945

I last saw him alive on Jan 22, 1945. Death is said to have occurred on the date stated above, at 2.30 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	1/23/45

Other contributory causes of importance:

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Bernard Lapp, M. D.

(Address) Volunteers of America Hosp.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE MUST BE FILLED OUT IN DUPLICATE. PHYSICIANS should be careful that information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 2

2465

X

G25096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G25096 Registered No.

JO #91643

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town ? Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Falls Pkt. ? S Chesterwood (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Cooper

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1879

8. AGE: Years	Months	Days	If less than one day
65	7	20	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Unable to obtain information.
11. Industry or business " " " "

FATHER
12. Name Richard Taylor Cooper (d)?
13. Birthplace England

MOTHER
14. Maiden Name Fannie Lowe (d) ?
15. Birthplace England

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JAN 24 1945 Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) JAN 24 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18, 1945, at 9:30AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17 1945, to 1-18 1945, and that I last saw him alive on 1-18 1945.

Immediate cause of death	Duration
cardiac failure	7
Due to Coronal thrombosis	
Due to emphysema and Unknown pulmonary disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C E Kerr Jr. M. D.
Address City Hosp. Date signed 1-19-45

VS 150

2466

625097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

625097

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital - D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 44 Market Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Zulauf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 69 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Joseph C. Zulauf
(b) Address 1606 Munsula Road, Towson, Md.

17 (a) Burial (b) Date thereof Jan. 25, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Road, B.A. Co.

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St.

19 (a) (b) Huntington Williams

JAN 24 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22 1945, at 11:25 A.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Walter J. Zulauch M.D.
Medical Examiner.
Date signed 1/27/1945

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G25098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G25098 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2202 E. Pratt St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 60 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2202 E. Pratt St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Bartlomiej Biniasz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Josephine Biniasz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10, 1877

8. AGE: Years 67 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Joseph Biniasz

13. Birthplace Poland

14. Maiden Name Magdalena Manczak

15. Birthplace Poland

16 (a) Informant Josephine Biniasz

(b) Address 2202 E. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/45 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus [illegible]

Location Baltimore County

18 (a) Funeral director John M. Lebon

(b) Address 401 S. Chester St.

19 (a) 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 1945, to Jan. 22 1945, and that I last saw him alive on Jan. 22 1945.

Immediate cause of death Cardiac Failure — Duration acute

Due to Coronary Heart Disease — ?

Due to Arterio-Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature. David J. Seeger M. D.

Address 2202 E. Pratt St Date signed 1/25/45

G25099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G25099

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 E 28th St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 E 28th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Previti

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Vincent
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14 1875

8. AGE: Years 69 | Months 5 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank Tonnato
13. Birthplace Italy

MOTHER
14. Maiden Name Dominica (Antonna)
15. Birthplace Italy

16 (a) Informant Julia Previti
(b) Address 1702 E 28th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore Md

18 (a) Funeral director Fallon & Lee
(b) Address 1217 S. Ford St

19 JAN 25 1945 Huntington Williams M.D. (Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1945, at 9:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944, to Jan. 24 1945, and that I last saw her alive on Jan 23 1945

Immediate cause of death: Pneumonia right leg. with metastases to abdomen.

	Duration
	7 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Turnquist M. D.
Address 511 Medical Arts Bldg Date signed 1/24/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

G25100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G25100 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 730 S. Charles St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 y.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 730 S. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Boone

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1 — 1899

8. AGE: Years 45 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Brunck Co Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Ead Macklin
13. Birthplace Va.

MOTHER
14. Maiden Name Lucillia Lambert
15. Birthplace Va.

16 (a) Informant Susie Boyd.
(b) Address 628 N. 25th St. Richmond Va.

17 (a) Removal (b) Date thereof 1/25/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Richmond Va.
Location

18 (a) Funeral director Walter B. Spragg
(b) Address 139 W. Hamburg Street

19 JAN 25 1945 (Date rec'd by Registrar) Municipal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 22 1944 to Jan 23 1945 and that I last saw h alive on Jan 23 19 45

Immediate cause of death	Duration
Carcinoma of breast	about 6 mos.
Due to	
Due to	
Other Conditions Metastasis to abdominal viscera	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John W. Haines M. D.
Address 6656 Bank St Date signed 1/24/45

VS 150

625101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 H

Registered No. 625101

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital - D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1909 Sherwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Alice V. Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown.

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Martinsburg W Va (Town, county, and state)

10. Usual Occupation Retired Plaster

11. Industry or business

FATHER
12. Name Anthony Brown
13. Birthplace

MOTHER
14. Maiden Name Catherine Hartman
15. Birthplace Frederick Md

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26 45 (month) (day) (year)
(c) Cemetery or crematory St Marys Edmondson
Location Baltimore Md

18 (a) Funeral director Frank T. Leib
(b) Address 814 N. 36 St.

19 (a) JAN 25 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23 1945 at 9:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Inhaling gas fumes from gas range

Other Conditions Decapodent

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/23/45 about 9:00 P.M.
(b) Where did injury occur? 1909 Sherwood Ave
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No.
(d) Means of injury Caused by inhalation of gas from gas range in kitchen of home

23. Signature C. F. Schumacher M.D. Medical Examiner.
Date signed 1/23/45

G25402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G25102

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 211 Camel St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11'

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 211 Camel Street (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country no

3 (a) FULL NAME Carrie Boyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 40 39 | Months | Days | If less than one day: hr. min.

9. Birthplace Newbert North Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name ?

13. Birthplace ?

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Charles H. Goulden

(b) Address 211 Camel Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Cedar Hill Md.

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave

19 (a) Jan 25 1945 (Date received by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24, 1946; at 3. A. M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 19 [illegible] and that I last saw him alive on [illegible] 19 [illegible].

	Duration
Immediate cause of death Bronchopneumonia	3 Days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed [illegible]

VS 150

625103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

625103 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3823 Clifton Av

(c) Hospital or institution: at home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Battolety

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3823 Clifton Ave

(If rural give location)

(e) Citizen of foreign country? -No- (Yes or No)

If yes, name country —

3 (a) **FULL NAME** Emily Jane Foard

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Norval E. Foard

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec-6-1855

8. AGE: Years 89 | Months 1 | Days 17 | If less than one day: hr. min.

9. Birthplace Randolph Co. N.C. (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER

12. Name Dr. Wm. W. Virdin

13. Birthplace Baltimore Md.

MOTHER

14. Maiden Name Katherine Dunn

15. Birthplace Fosting Monroe-Va.

16 (a) Informant Mrs Katharine F. Franklin

(b) Address 3823 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan-25-45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville-Md.

18 (a) Funeral director Stewart Mowen Co.

(b) Address 1084 W North Ave.

19 (a) Filed (b) Huntington Williams Registrar

JAN 25 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23-1945 at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20-1945, to 1-23 1945. and that I last saw her alive on 1-22 1945.

Immediate cause of death: cerebral thrombosis — Duration: 24 hr

Due to: General arterio sclerosis — Duration: year

Due to: age —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature S. C. Dumas M. D.

Address Medical Arts Bldg (Date signed)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G25104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G25104
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 days
(e) Length of stay in Baltimore (yrs., mos., or days) 89 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 291 Riggs Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Lauterbach

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Anna M. Lauterbach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7, 1855

8. AGE: Years 89 | Months 4 | Days 14 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Ed. Baker.
11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Family
(b) Address 291 Riggs Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 1-25-45 (month) (day) (year)
(c) Cemetery or crematory Leakin Park
Location Frederick Highway

18 (a) Funeral director J. L. Kirkland
(b) Address 15 E. Fort Ave.

19 (a) (Date rec'd by registrar) JAN 25 1945 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/21 1945, at 2:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1945 to 1/25 1945 and that I last saw him alive on 1/20 1945.

Immediate cause of death	Duration
Cardiac Failure	Several
Due to Arteriosclerotic cardio-vascular dis ease	Several years.
Due to	
Other Conditions Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	

Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Percy Fuller Gorman M. D.
Address University Hospital Date signed 1/23/45

X

G25105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G25105 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3004 Ferndale Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 Ferndale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Rode

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race Wht. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Geo. H. Rode

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1873

8. AGE: Years 71 | Months 3 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md.
(Town, county and state)

10. Usual Occupation Houses - Wife

11. Industry or business

FATHER 12. Name Amos Handley
13. Birthplace Md.

MOTHER 14. Maiden Name Mary Knox
15. Birthplace Md.

16 (a) Informant Edward B. Rode
(b) Address 3004 Ferndale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27, 1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md

18 (a) Funeral director Robert S. Lisle
(b) Address 2708 Edmondson Ave

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

VS 150 JAN 25 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 1945; at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1944, to Jan 23 1945, and that I last saw h-- alive on 1-23 1945

Immediate cause of death Coronary Thrombosis — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm R Johnson M. D.
Address 403 Medical Arts Bldg Signed 1-24-45

625106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

625106 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 Elmwood Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 Elmwood Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Millard N. Dietl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Viola S. Dietl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20th 1893

8. AGE: Years	Months	Days	If less than one day
51	5	3	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Secretary
11. Industry or business Sun Life Ins. Co

FATHER
12. Name Edward C. Dietl
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma Foster
15. Birthplace Balto. Md.

16 (a) Informant Viola S. Dietl
(b) Address 10 Elmwood Rd

17 (a) Burial (b) Date thereof 1/25/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Druid Ridge
Location Pikesville Md

18 (a) Funeral director William Cook Inc
(b) Address 12 E. Saint Paul St.

19 (a) JAN 25 1945 Huntington Williams, M.D.
(Date received by local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23rd 1945, at 8a.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1941 to Jan 23 1945
and that I last saw him alive on Jan 23 1945

Immediate cause of death Coronary Sclerosis — Duration 4yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leo M. Gaar M. D.
Address 705 Mosher Date signed 1/25/45

VS 150

X

625107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625107
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 424 Myrtle ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 424 Myrtle ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Selby Dorkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Widow

6 (b) Name of husband or wife William H
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 3-13-1887

8. AGE: Years	Months	Days	If less than one day
57	10	9	hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation House Work
11. Industry or business

FATHER
12. Name Austin Selby
13. Birthplace N. C.

MOTHER
14. Maiden Name Aquilla ?
15. Birthplace N. C.

16 (a) Informant Virginia Bailey
(b) Address 1013 W. Mulberry st

17 (a) Burial (b) Date thereof 1 27 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Wm A Jackson
(b) Address 916 Pelham ave

19 (a) 1-25-45 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1945, at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/17 1945 to 1/22 1945, and that I last saw him alive on 1/20 1945.

Immediate cause of death	Duration
Cardio - Vascular Renal disease	1 yr.
Due to Hypertension Years.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. A. Jackson M. D.
Address 6008 Belmont Ave Signed 1/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

JO #91724 G25108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G25108 Registered No. 15 1a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 Division Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Cooper or Gertrude Savage

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1896

8. AGE: Years 49 ? | Months ? | Days ? | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation House work
11. Industry or business

FATHER
12. Name James Savage)d(
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mary Bond)d(
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 1-25-45 (month) (day) (year)
(c) Cemetery or crematory Edenton Cemetery
Location Edenton N. Carolina

18 (a) Funeral director William A. Jackson
(b) Address 916 Pember ave

19 JAN 25 1945 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 1945, at 7:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from January 21, 1945 to Jan. 22, 1945, and that I last saw her alive on Jan. 21, 1945

Immediate cause of death Uremia — Duration

Due to arteriolar nephrosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. E. Perry M. D.
Address City Hosp. Date signed 1/24/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. G25109

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 o Calvert St
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo. 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6217 Burgers Ave, Hamilton (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Vincent Lee

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of ~~XXXX~~ or wife Rosalie (nee Sappe)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18, 1871

8. AGE: Years	Months	Days	If less than one day
74	0	4	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Michael Lee (D)
13. Birthplace England

MOTHER
14. Maiden Name Mary ? - (D)
15. Birthplace England

16 (a) Informant Edward W. Lee
(b) Address 6217 Burgers Ave, Hamilton City,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/45 (month) (day) (year)
(c) Cemetery or ~~XXXX~~ Parkwood
Location Baltimore Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street Huntington Hollows, Md.

19 (a) Jan 24 1945 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1945, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1944, to Jan 22 1945, and that I last saw him alive on Jan 22 1945.

Immediate cause of death	Duration
Cardiac Failure	
Due to Arteriosclerotic Cardio vascular disease	
Due to	
Other Conditions 1st & 2nd degree burns of both legs, healed. (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Nov. 7, 1944 at 11: P M
(c) Where did injury occur? Baltimore (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury Burns when cigar burned pajamas

23. Signature Paul S. Crane M. D.
Address Union Memorial Hospital Date signed Jan. 23, 1945

Approved: John R. Davis M.D. per Rosalie Graham M.D.

VS 150

625110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

625110 Registered No.

MARYLAND RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore #18
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ambassador Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Pearre E. Crowl

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-16-9004

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife: Mary Crowl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1862

8. AGE: Years	Months	Days	If less than one day
83	0	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired Builder
11. Industry or business

FATHER
12. Name David Crowl
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline Revell
15. Birthplace Md.

16 (a) Informant Mrs. Mary B. Crowl
(b) Address Ambassador Apartments

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 27 1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 (a) JAN 25 1945 (Date received by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 1945, at 12:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23 1945, to Jan. 24 1945, and that I last saw him alive on Jan. 24 1945.

Immediate cause of death	Duration
Cardio-Respiratory failure and pulmonary hemorrhage	
Due to Cardiac Decompensation and Uremia.	
Due to	
Other Conditions Carcinoma of the bladder. (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph W. West, M.D. M. D.
Address Md. Gen. Hospital Date signed Jan 24, 1945

95C

625111

625111

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 1310

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 So Fremont St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Dixie Richard Green

If U. S. Veteran specify WAR

(a) Residence: No. 226 So. Fremont St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) March 14 1896

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	10	7	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Baltimore Ohio R R

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Laborer

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Alabama
(State or country)

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) Unknown
(State or country)

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) Unknown
(State or country)

17. INFORMANT Esa Green
(Address) 226 So Fremont ave

18. BURIAL, CREMATION, OR REMOVAL
Place Mount Lion Date Jan 26, 1945

19. UNDERTAKER Joseph A. Lively
(Address) 1824 W Mount Street

FILED JAN 25 1945 for Williams, M.D.
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) June 21, 1945

22. I HEREBY CERTIFY, That I attended deceased from June 15, 1945 to June 21, 1945

that saw h alive on June 15, 1945. Death is said to have occurred on the date stated above, at 7:40 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	

Other contributory causes of importance:

Hypertension
Chronic Nephritis

Was an operation performed? Date of

For what disease or injury?

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) M Williams M. D.

(Address) 803 E Fremont Ave

N. B.—WRITE PLAINLY, IN INK. ALL QUESTIONS MUST BE ANSWERED. AGE should be stated EXACTLY. PHYSICIANS should be careful to see that information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to see that it may be properly classified. Exact statement of state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

5112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625112

Registered No. 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 924 S. Bean St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie Sitta

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-25-92

8. AGE: Years 52 | Months 11 | Days 28 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Sitta.
13. Birthplace Va.

MOTHER 14. Maiden Name Minnie Rains
15. Birthplace Va.

16 (a) Informant records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26, 1945 (month) (day) (year)
(c) Cemetery or crematory Arlington Mem Park
Location Baltimore County, Md

18 (a) Funeral director Joseph A. Lively
(b) Address 408 N. Mount Street

19 (a) JAN 25 1945 (Date rec'd by registrar) (b) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22-1945, at 3:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17-1944 to 1-22-1945, and that I last saw h-er alive on 1-22-1945.

	Duration
Immediate cause of death Suffocation due to aspiration of vomitus	98 days
Due to	
Due to	
Other Conditions Diabetes Mellitus, Hypertensive Cardio-vascular disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature YC Meacham M. D.
Address JH Hospital Date signed 1-22-45

VS 150

195D

625113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

64

625113
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1818 N. Pulaski St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joslyn Schindlia

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/10/44

8. AGE: Years	Months	Days	If less than one day
	1	14	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Harry Schindlia
13. Birthplace Russia

MOTHER
14. Maiden Name Bertha Rose
15. Birthplace Baltimore - Md

16 (a) Informant Harry Schindlia
(b) Address 1818 N. Pulaski St.

17 (a) Burial (b) Date thereof 1-25-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd. & Hamilton Ave

18 (a) Funeral director Jack Lewis, Inc.
(b) Address 1439 E. Baltimore St.

19 (a) JAN 25 1945
(Date received by registrar) Huntington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1945, at 1:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to hes death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status Thymico-Lymphaticus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gutstein M.D.
Medical Examiner.
Date signed Jan. 25 1945

VS 151

MARG... RESERVED FOR B...

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

625114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625114

Registered No. 44B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument & Rutland

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1904 Highgate Road (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Sarah Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Russia

MOTHER 14. Maiden Name Unknown

15. Birthplace Russia

16 (a) Informant Martin Richmond

(b) Address 1904 Highgate Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-45 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Baltimore Co.

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 25 1945

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24 1945, at 5:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6/44 19 to 1/24 1945.

and that I last saw her alive on 1/24 19 45.

Immediate cause of death: Cardio Resp Failure

Due to: Lymphoma Coma

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J Simmons M. D.

Address Sinai Hospital Date signed 1/25/45

X

625115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. 625115

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1617 N. Port St.
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 N. Port St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carmela D'Aloiso

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ late Savino
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3rd 1879

8. AGE: Years	Months	Days	If less than one day
65	10	20	hr. min.

9. Birthplace Vasto Girardi Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Giuseppe Franceschetti
13. Birthplace Italy

MOTHER
14. Maiden Name Frosina ?
15. Birthplace Italy

16 (a) Informant Joseph D'Aloiso (Son)
(b) Address 1617 N. Port St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Jan. 26/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave & Rose St.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

19 JAN 25 1945 (b) Huntington Williams, M.D. Registrar
(Date received by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1945 to Jan 23 1945, and that I last saw h. alive on Jan 23 1945

Immediate cause of death	Duration
Hypernephroma + general abdominal Carcinoma	6 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. B. Wheeler M.D.
Address 1-279 William N Date signed 1/24/45 M. D.

625116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625116 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd Street
(c) Hospital or institution: Union Memorial Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Register Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Palmer Andrew Dahler
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mrs Annie Dahler
6 (c) If alive, give age ~~if dead~~ years

7. Birth date of deceased (mo., day, yr.) Feb 13, 1898

8. AGE: Years	Months	Days	If less than one day
46	11	76	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Landscape Gardener.
11. Industry or business

FATHER
12. Name Henry Dahler
13. Birthplace ?

MOTHER
14. Maiden Name Ida Daenoch
15. Birthplace ?

16 (a) Informant Mrs. Anna E. Dahler
(b) Address 1010 Register Ave, Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 27, 1945 (month) (day) (year)
(c) Cemetery or crematory St. Johns Cem. Location Glenheim, Balto Co., Md

18 (a) Funeral director John Byrne & Bro Towson, Md.
(b) Address

19 (a) JAN 25 1945 (Date received by registrar) (b) Huntington Williams MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24 1945 at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1944 to 1-26 1945 and that I last saw h/M alive on 1-25 1945.

Immediate cause of death Respiratory failure — Duration

Due to Brain Abscess

Due to Draining empyema

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Lippett M. D.
Address Union Memorial Hosp Date signed 1/27/45

G25117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G25117 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 835 E BELVEDERE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 835 E Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY J BOTHE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MATHILDA

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 9-1866

8. AGE: Years	Months	Days	If less than one day
78	10	15	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name H. Julius Bothe
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Muhly
15. Birthplace Baltimore Maryland

16 (a) Informant Henry C. Bothe
(b) Address 5604 Plymouth Rd.

17 (a) Burial (b) Date thereof Jan 26 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorbrook
Location Baltimore County

18 (a) Funeral director Mrs Edward A Roblee
(b) Address 2327 Edmondson Ave

JAN 25 1945 Hunting for Williams M.F.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1945 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1944 to Jan 24 1945 and that I last saw h[illegible] alive on Dec 15 1944

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	10 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. S. Chaffee M. D.
Address 6 W York Rd Date signed Jan 25, 45

X

VS 150

625118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91a

Registered No. 625118

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1732 N. Calhoun St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 N. Calhoun St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie P. Gibson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1882

8. AGE: Years: 62 | Months: 9 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Matthews Co Va (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Peter Thompson
13. Birthplace: Va

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Wm G. Gibson
(b) Address: 1736 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/1945 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Mem. Pk.
Location: Baltimore Co. Md

18 (a) Funeral director: Mrs Chas. H. Hudson
(b) Address: 1631 Druid Hill Ave

19 (a) 1-25-1945 [illegible] Registrar
(Date rec'd by reg'r)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 1945 at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Vegetative Endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Robert Lee Preston M.D.
Medical Examiner.
Date signed Jan 23 1945.

VS 151

GR5113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1945 Registered No. GR5119

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2122 Broening Hwy
(c) Hospital or institution: Eastern Aviation Craft
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) (GR! Double)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 250 # Madison Ave (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Faustina Foote

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Maxell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 6, 1919

8. AGE: Years 26 | Months - | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Defense worker

11. Industry or business Eastern Aircraft

FATHER
12. Name J. Kendell Grinnage
13. Birthplace Wash. D. C.

MOTHER
14. Maiden Name Louena
15. Birthplace Michigan

16 (a) Informant J. Kendell Grinnage
(b) Address 2605 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 27 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Wm. George A. Hulbert
(b) Address 1631 Druid Hill Ave.

19 (a) JAN 25 1945 (Date rec'd by registrar) (b) Hunter Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1945 at 5:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner.)
Date signed 1-24-45

625120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625120 Registered No. 555

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2000 N. Hilton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2000 N. Hilton St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice J. Sullivan

3 (b) If veteran, name war

3 (c) Social Security Account No. 024-09-2255

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Jane M. Sullivan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1886

8. AGE: Years	Months	Days	If less than one day
58	11	11	hr. min.

9. Birthplace Bloomfield, N.Y.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Michael Sullivan
13. Birthplace N. Y.

MOTHER
14. Maiden Name Mary Cronin
15. Birthplace N. Y.

16 (a) Informant Mrs. Jane M. Sullivan
(b) Address 2000 N. Hilton St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 26, 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) JAN 25 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23, 1945, at 4.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1943 to Jan 23 1945, and that I last saw him alive on Jan 21 1945.

Immediate cause of death Squamous cell carcinoma of a branchial cyst of neck. — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma branchial cyst of neck.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. F. Sullivan M. D.
Address 291 Garrison Blvd Date signed 1-24-45

VS 150

625121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625121

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 828 S. Rappolla St.,

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 828 S. Rapppolla St.,
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Wilson Coulbourne

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lula H. Coulbourne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1859

8. AGE: Years	Months	Days	If less than one day
85	7	16	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Retired Farmer

11. Industry or business

FATHER
12. Name William Coulbourne
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Wilson
15. Birthplace Md.

16 (a) Informant Mrs. Lula H. Coulbourne

(b) Address 828 S. Rappolla St.,

17 (a) Burial (b) Date thereof Jan. 26, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Parkville, Md.

18 (a) Funeral director J. Howard Strong

(b) Address 3207 W. North Ave.,

19 (a) JAN 25 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23, 1945 at 3 43 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2 1940 to 1/23 1945 and that I last saw him alive on 1/23 1945

Immediate cause of death	Duration
Pulmonary edema	5 hrs.
Due to Arteriosclerotic heart disease	8 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Robert A. Reuter M. D.

Address 2401 Wilkens Ave Date signed 1/25/45

VS 150

G20122
467498

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G20122
Registered No.

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Somerset
(c) City or town Inverness
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 Bayside Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Lindenmayer

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: JOSEPH LINDENMAYER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-1-60

8. AGE: Years 84 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace Hungary.
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name Joseph. Organ
13. Birthplace Hungary

MOTHER
14. Maiden Name Anna SCHUDLBERG
15. Birthplace Hungary.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) CREMATION (Burial, cremation, or removal) (b) Date thereof JAN. 26/45 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDERICK AVE.

18 (a) Funeral director Lilly and Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 JAN 25 1945 (Date received by registrar) (b) Huntington Willis Pendleton M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1945, at 7.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 1945 to Jan 23 1945 and that I last saw h.m. alive on Jan 23 1945

Immediate cause of death: Pulmonary congestion — Duration
Due to: cardiac decompensation
Due to: Arterio-sclerotic Heart disease.
Other Conditions: Diabetes, amputation rt. leg.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George Bunch M.D.
Address J. H. H. Date signed 1-24-45

93D

625123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31/a

Registered No. 625123

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3720 Hudson Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3720 Hudson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** FREDERICK CONRAD LANG

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Mary Elizabeth Lang
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 25,1859

8. AGE: Years	Months	Days	If less than one day: hr.	min.
85	11	29		

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Ret. Watchman
11. Industry or business

FATHER
12. Name ? Lang
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Fred C. Lang (Son
(b) Address 3720 Hudson Street

17 (a) Burial (b) Date thereof 1-27-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory First Evangelical
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 JAN 25 1945 Registrar for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24, 1945, at 1.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1945 to 1/24 1945 and that I last saw h alive on 1/24 1945

Immediate cause of death: Acute Cardiac Dilatation — Duration

Due to Hypostatic Pneumonia

Due to Cardio renal.

Chronic Pancreatic Congestion

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Carroll M. D.
Address 603-5 Cookling Date signed 1/24/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832

625124

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1642 Chilton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1642 Chilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Harry Lessner

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-2490

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dolores S. Lessner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 5 1890

8. AGE: Years	Months	Days	If less than one day
54	10	19	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Floor Mgr.

11. Industry or business Stutzler Bros.

FATHER
12. Name John D. Lessner
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name ——— Wolf.
15. Birthplace Baltimore Md

16 (a) Informant Dolores S. Lessner
(b) Address 1642 Chilton St

17 (a) Burial (b) Date thereof Jan 29/1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Harry A. Ammann
(b) Address 4204 Ridgewood Ave

19 (a) JAN 25 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1945, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940, to Jan 24 1945, and that I last saw him alive on Jan 24 1945.

Immediate cause of death	Duration
Bronchopneumonia	3 days
Due to Cerebral Hemorrhage + Cerebral Softening	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. H. Haywood
Address 115 Eager St. Date signed 1-25-45
M. D.

VS 150

625125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

625125 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1300 N.Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 N.Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm.H.Purvis

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.3-1886

8. AGE: Years	Months	Days	If less than one day
58	3	20	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Merchant Marine
11. Industry or business

FATHER
12. Name Purvis
13. Birthplace Ireland

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mrs. Carrie Berger
(b) Address 1300 N.Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan.26/45 (month) (day) (year)
(c) Cemetery or crematory New Balto National Cem.
Location Frederick Rd

18 (a) Funeral director John L. Miller
(b) Address 2334 Jefferson St.

19 (a) JAN 25 1945 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1945, at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 22 1944 to Jan 23 1945, and that I last saw h[illegible] alive on Jan 22 1945.

Immediate cause of death	Duration
Coronary Thrombosis	10hrs
Due to Arteriosclerosis.	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Peter P. Sikorsky
Address 939 N. Eden St. Date signed 1/25/45

G25126

AB-15766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G25126 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs- 6mos- 24days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. No home
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leon or Beau Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-1890 or 1890

8. AGE: Years	Months	Days	If less than one day
~~65~~ or 55	?	?	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Henry Green
13. Birthplace Md.

MOTHER
14. Maiden Name Mollie Green
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JAN 25 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 JAN 25 1945 Attending for Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19- 1945, at 1.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-26 1935, to 1-19 1945 and that I last saw h im alive on 1-19 1945.

Immediate cause of death Cardiac insufficiency

Due to

Due to

Other Conditions Rheumatoid arthritis deformans
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration
7

7

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Elizabeth Woodward M. D.

Address Baltimore City Hospitals Date signed 1-24-45

VS 150

2470

Original Certificate of Death in document file

COPY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G-25127

MARKS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 Irving Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 Irving Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norma Lee Hurley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1944

8. AGE: Years	Months	Days	If less than one day
	two	14	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Norman W. Hurley
13. Birthplace Welch, West Virginia

MOTHER
14. Maiden Name Virginia Husten
15. Birthplace Withville, Virginia

16 (a) Informant Virginia Hurley
(b) Address 18 Irving Place

17 (a) Royal Retreat, Va. (b) Date thereof Jan. 26, 1945
(Interment or removal) (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director M.W.E.Dippel's Sons
(b) Address Lombard & Ann Streets

19 (a) Jan. 25, 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1945 at 9:00 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23 1945, to Jan. 24 1945, and that I last saw her alive on Jan. 24 1945.

Immediate cause of death	Duration
Broncho-Pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Silverstein

Address 22 S. Broadway Date signed 1/25/45 M.D.

VS 150

625128 TANSILL

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43E

625128 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hosp
(c) Hospital or institution: 2025 W. Fayette St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City of town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 E. Fitzhugh St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle Cecelia Tansill

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife William Boyd Tansill
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 7-19-1899

8. AGE: Years	Months	Days	If less than one day
21 yrs.	6	8	hr. min.

9. Birthplace Md Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward F. Miller
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret T. Flannigan
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Edw. F. Miller
(b) Address 410 E. Fitzhugh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Flynn & Fleming
(b) Address 14 No Light St.

JAN 25 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25 1945, at 3 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24 1945 to 1/25 1945 and that I last saw h[illegible] alive on 1/25 1945.

Immediate cause of death Acute Cardiac Dil. — Duration Hours

Due to Myocarditis — Not Known

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Edward Flynn
Address 107 East Lexington St Date signed 1/25/45 M. D.

VS 2

8

X

625129 BALTIMORE CITY HEALTH DEPARTMENT 625129

CERTIFICATE OF DEATH V161a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: Sarah Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11hrs
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. 25, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 Jack Place. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James William Blankenship
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex M
5. Color or race W.
6 (a) Single, married, widowed, or divorced. —
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 24, 1945
8. AGE: Years | Months | Days | If less than one day 17 hr. 22 min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Newborn
11. Industry or business —

FATHER
12. Name Orville Lee Blankenship
13. Birthplace Cumberland, Ky.

MOTHER
14. Maiden Name Pearl Irene Gley
15. Birthplace Dungo Center, W. Va.

16 (a) Informant Pearl Irene Blankenship (mother)
(b) Address 1007 Jack Place.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26, 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ayrsdale Rd & C&O

18 (a) Funeral director Stephen J. Fleming
(b) Address 1426 Light St

19 (a) JAN 26 1945 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 1945, at 7:55 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 1:07 PM 1945, to 6:22 AM 1945, and that I last saw him alive on 6/22 6/22/1945.
Immediate cause of death A Fibrillation — Duration
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: A Fibrillation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature James Brown M. D.
Address 705 Medical Arts Date signed 1/25/45

625130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

625130 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Balt. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1328 South Hanover St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Walter Daniel Littlelow

3 (b) If veteran, name war

3 (c) Social Security Account No. 108-12-1895

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Addie H. Littleton

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) July 27-1870

8. AGE: Years 74 | Months 5 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Folling Creek Caroline Co. Md. (Town, county, and state)

10. Usual Occupation Retired Trainman

11. Industry or business B+O. R.R.

FATHER
12. Name William James Littleton
13. Birthplace Dorchester Co. Md.

MOTHER
14. Maiden Name Elizabeth Jane Bell
15. Birthplace Dorchester Co. Md.

16 (a) Informant Wm. James L. Littleton
(b) Address 18-East 22nd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27-45 (month) (day) (year)
(c) Cemetery or crematory Mount Carmel
Location Balto. Maryland

18 (a) Funeral director A. Howard Evans
(b) Address 1400 S. Charles Street

19 (a) 1945 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 1945, at 11 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 12 1945, to Jan. 24 1945, and that I last saw h/ alive on Jan. 24 1945

Immediate cause of death Bilateral lobar pneumonia — Duration

Due to

Due to

Other Conditions Arteriosclerotic C-V disease Intestinal obstruction (Include pregnancy within 3 months of death)

Date of operation Jan. 16, 1945

Major findings of operation: Intestinal obstruction + obstruction released

of autopsy: same as above except no obstruction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul G. Lukats M. D.
Address 1213 Light St. Date signed 1-24-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. current age is especially important.

MARG. RESERVED FOR BINDING

VS 150

625131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. 625131

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 421 Yale Ave.
(c) Hospital or institution: 2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 421 Yale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widower

6 (b) Name of husband or wife late Wilhelmina Haugsdat
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1873

8. AGE: Years	Months	Days	If less than one day
82		15	hr. 18 min. 63

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Blacksmith
11. Industry or business B & O. R.R.

FATHER
12. Name —Schneider
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Mr. Carl Schneider Jr.
(b) Address 421 Yale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/45 (month) (day) (year)
(c) Cemetery or crematory St. Paul
Location Violetville Md.

18 (a) Funeral director Harry A. Wiltze
(b) Address 4101 6 Almond Sts.

JAN 26 1945 (Date received by Registrar) per Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1945, at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22-1945 to 1-23-1945 and that I last saw him alive on 1-23-1945

Immediate cause of death	Duration
Acute Cardiac Dilatation:	few minutes
Due to Cardiac Hemorrhage.	1 day.
Due to Carcinoma Stomach.	6 mo.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James Graham Thornton M. D.
Address 516 Cathedral St. Date signed 1-25-45

VS 150

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1 Transcript

625132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. 625132

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 813 Homestead St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Homestead St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret L. Judy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife William C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 7, 1879

8. AGE: Years	Months	Days	If less than one day
65	1	16	hr. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jacob G. Carney
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Mary Chase
15. Birthplace Washington D.C.

16 (a) Informant Mr. William C. Judy
(b) Address 813 Homestead St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry A. Wilhelm
(b) Address 4101 Edmondson Ave.

JAN 26 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1945, at 8 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1942 to Jan 1945, and that I last saw her alive on Jan 23 1945.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Myocarditis	5 yrs
Arteriosclerosis	10 yrs
Due to Cerebral Hemorrhage	2 yrs
	38 yrs

Other Conditions Endocarditis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Geo. L. Zimmerman M. D.
Address 2858 Harford Rd Date signed 1/24/45

VS 150

625133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

Registered No. 625133

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15-11 Calhoun st (If rural give location)
(e) Citizen of foreign country? N o (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Kerner WHERLE WHERLE (PATTISON)
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Otto C
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Apr 10 1888
8. AGE: Years 56 Months 9 Days 14 If less than one day hr. min.
9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business
FATHER 12. Name Laurence Kerner
13. Birthplace Md
MOTHER 14. Maiden Name Mary E Murphy
15. Birthplace Md
16 (a) Informant Laurence Kerner
(b) Address 1500 W Fayette st
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-45 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Balto Md
18 (a) Funeral director Geo A Foley
(b) Address Sutton & Fayette
19 (a) JAN 26 1945 (Date rec'd by Registrar) (b) Registrar Hunter for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24 1945; at 4 58 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 1-8 1945 to 1-24 1945 and that I last saw her alive on 1-24 1945
Immediate cause of death Right heart failure — Duration
Due to Cor pulmonale
Due to Ayerza's disease
Other Conditions Syphilis
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R B Marmont M.D.
Address Univ Hosp Date signed 1/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important. MARGIN RESERVED FOR BINDING

VS 150

95c

625134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

625134 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette E Pulaski

(c) Hospital or institution Bon Secours Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto Md

(If outside city or town limits, write RURAL and give town)

(d) Street No. 512 Charing Cross

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME John P Cadogan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 24 1867

8. AGE: Years	Months	Days	If less than one day
77	6	29	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER

12. Name Thomas Cadogan

13. Birthplace Ireland

MOTHER

14. Maiden Name Mary Denville

15. Birthplace Ireland

16 (a) Informant Mrs. Jas. L Ball

(b) Address 512 Charing Cross

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-46 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore Md

18 (a) Funeral director Geo A Farley

(b) Address Tudor & Fayette

19 (a) (b) Registrar

JAN 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23 1945, at 11:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/13 1945 to 1/23 1945 and that I last saw h[illegible] alive on 1/23 1945.

Immediate cause of death Broncho pneumonia Lobular Pneumonia Upper Right, Lower Right — Duration 2 wks.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Broncho-Lobular Pneumonia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Richard C. Hayden M. D.

Address Bon Secours Hosp Date signed 1/23/46

X

625135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

625135
Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2535 Park Heights Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-13
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2535 Park Heights Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PEARL GREENSTEIN

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Isaac
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Hersch
13. Birthplace Russia

MOTHER
14. Maiden Name Hendel
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-45 (month) (day) (year)
(c) Cemetery or crematory Wash. Blvd
Location Linthicum Heights Rd.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balt St.

19 (a) JAN 26 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1944 to 1/26 1945, and that I last saw h alive on 1945.

Immediate cause of death Chron Myocarditis — Duration 2yrs
Due to
Due to Edema of lungs — 1 day
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature W. J. Bayless M.D.
Address 7040 Eastern Ave Date signed 1-26-45

625136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

625136
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 N Gilmor St.
(c) Hospital or institution: None
(d) Length of stay in hospital or inst. (yrs., mos., or days) mos
(e) Length of stay in Baltimore (yrs., mos., or days) 3 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto 17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 N. Gilmor St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Leo Mathews Brown

3 (b) If veteran, name war No
3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Single

6 (b) Name of husband or wife NO
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 25, 1945

8. AGE: Years	Months	Days	If less than one day
0	0	0	3 hr. 0 min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business Infant

FATHER
12. Name Leo Mathew Brown
13. Birthplace Balto Md

MOTHER
14. Maiden Name Beatrice Watson
15. Birthplace Balto Md

16 (a) Informant Beatrice Watson Brown
(b) Address 10 N Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 3221 Schroeder St

19 (a) (Date of disinterment) (b) Hunting for Hilltop, Md.

JAN 26 1945

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1945 at 2:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1945 to Jan 25 1945 and that I last saw h alive on Jan 25 1945.

Immediate cause of death Congenital Atelectasis — Duration

Due to Prematurity 3 1/2 lb

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James L. Shanfe M. D.
Address University Hospital Date signed 1-25-45

X

625137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

625137 Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene St.
(c) Hospital or institution: University Hospital 22

(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 545 W. Barre St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1943

8. AGE: Years	Months	Days	If less than one day
1	6	9	hr. min.

9. Birthplace Randall Co. N. Carolina (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Lonnie Johnson
13. Birthplace Franklin Co, N. Carolina

MOTHER
14. Maiden Name Mary Lee
15. Birthplace Randall Co, N. Carolina

16 (a) Informant Mary Johnson
(b) Address 545 W. Barre St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1/26/1945 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location Westport

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) [illegible] (Date rec'd by registrar 1945) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23 1945, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1944, to 1/23 1945, and that I last saw h[illegible] alive on 1/2 1945.

Immediate cause of death	Duration
Respiratory Failure	38 Days
Due to Overwhelming Infection	
Due to 2nd & 3rd Degree Burns of 47% of Body Surface	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Dec 14, 1945 at M
(c) Where did injury occur? Baltimore (City or town) (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury Stove exploded

23. Signature William H. Hoard M. D.
Address Univ Hospital Date signed

Jan. 27 1945 Chester J. Lubinski M.D. Robert Gruber M.D.

625138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625138 Registered No.

YA-14227

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 yrs., 8 mos., 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town NO HOME
(If outside city or town limits, write RURAL and give town)
(d) Street No. ..... (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Sam Allen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1882

8. AGE: Years 62 | Months - | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name William
13. Birthplace ?

MOTHER
14. Maiden Name Sally Chiness
15. Birthplace ?

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/45 (month, day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Sharp Street

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) JAN 26 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 1945 at 4:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-19 1936, to 1-22 1945, and that I last saw him alive on 1-22 1945.

Immediate cause of death: Bilateral lobar pneumonia — Duration: ?

Due to .....

Due to .....

Other Conditions Cortico Bronchitis due to Lipolulebe cortetis
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: Some

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Elizabeth Woodward M. D.
Address Baltimore City Hospitals Date signed 1-24-45.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

625139
YA-75769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

✓ 625133
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs., 5 mos., 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Belto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 Waldo St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James B. Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1872

8. AGE: Years	Months	Days	If less than one day
72	3	7	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name John Green (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Florence (d)
15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Sharp St.

18 (a) Funeral director A. J. Halstead
(b) Address 908 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23, 1945, at 12:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1 1942, to 1-23 1945, and that I last saw h im alive on 1-23 1945.

Immediate cause of death	Duration
Bilateral lobar pneumonia	1 wk?
Due to	
Due to	
Other Conditions Syphilitic aortic & aneurysm ? Ca of Stomach ? (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Same.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth Woodward M. D.
Address Baltimore City Hospitals Date signed 1-24-45

VS 150

108

625140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

✓ 625140 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 West North Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANTHONY J. McHALE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jennie F. McHale

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 7 1885

8. AGE: Years 59 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Retired Police

11. Industry or business: Balto. Police Dept.

FATHER
12. Name: William McHale
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Honora Kelly
15. Birthplace: Ireland

16 (a) Informant: Mrs. Jennie McHale
(b) Address: 1810 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/45 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Baltimore

18 (a) Funeral director: Martin Lafferty Inc.
(b) Address: 182 W. North Ave.

19 (a) (b) Huntington Williams, M.D. (Died or Dead on registrar)

JAN 26 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24, 1945, at 5:17 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.

Date signed 1/25/45

G25141
466112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G25141

Registered No. 1248

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Lanvale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Bruggeman

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-3682

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widower

6 (b) Name of ~~husband or~~ wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-10-84

8. AGE: Years	Months	Days	If less than one day
60	3	13	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Bar. tender.

11. Industry or business

FATHER 12. Name Otto Bruggeman

13. Birthplace Germany.

MOTHER 14. Maiden Name Barbara Zimmerman

15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1/27/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location Balto, Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (a) JAN 26 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 - 1945 at 1.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22 1944 to Jan. 23 1945 and that I last saw him alive on Jan. 23 - 1945.

Immediate cause of death Ruptured esophageal varix

Due to cirrhosis of liver

Due to

Other Conditions Splenic renal vein thrombosis

(Include pregnancy within 3 months of death)

Date of operation 1-15-45

Major findings of operation: cirrhosis of liver, small spleen, omentum adherent to peritoneum

of autopsy: cirrhosis, varices, esophagus, thrombosis

Duration
Symptoms of 3½ months duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Bunch M. D.
Address J. H. H. Date signed 1-24

VS 150

625142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

625142 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution:
South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y.C. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 375 CENTRE PARK - WEST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert C. Rodgers

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Marcia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 32 | Months 31 | Days | If less than one day ... hr. ... min.

9. Birthplace New York N.Y.
(Town, county, and state)

10. Usual Occupation Mariner
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Doe
(b) Address Mercantile Trust Bldg

17 (a) Buried (b) Date thereof 1-29-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Baltimore Md

18 (a) Funeral director Wilson Funeral Inc
(b) Address 1707 E Fort Ave

19 (a) JAN 26 1945 (b) Washington Hill
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1945, at 1A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-24- at 24|1 A M.
(b) Where did injury occur? Foot of Hull St: Balto. City Harbor
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed January 24, 1945.

625143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 625143

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Treasury Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Edward Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Nov 27th 1883

8. AGE: Years	Months	Days	If less than one day
61	1	29	hr. min.

9. Birthplace Somerset Co., Md.
(Town, county, and state)
10. Usual Occupation Port - watchman
11. Industry or business Steamships Trade Assoc

FATHER
12. Name Robert Henry Johnson
13. Birthplace Somerset Co. Md.

MOTHER
14. Maiden Name Maria Esther Moore
15. Birthplace Somerset Co. Md.

16 (a) Informant Robert Scheck
(b) Address Towson, 1970 Mc

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Maryland

18 (a) Funeral director William Cook - Inc
(b) Address 1247 St. Paul St.

19 (a) JAN 26 1945 (Date rec'd by registrar) (b) Ernestine Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1945, at 1.45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Exis death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 1-25-45

G25144 Blimline

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 137a

G25144

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Sinai Hos

(c) Hospital or institution: Rutland · Monument 2b

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 334 S Wenkith St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Harry Blimline

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 11 1882

8. AGE: Years	Months	Days	If less than one day
62	10	13	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER 12. Name George Blimline

13. Birthplace Germany

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Edw C Blimline

(b) Address 104 S Fayette

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/45 (month) (day) (year)

(c) Cemetery or crematory Schwartz

Location Balto Md

18 (a) Funeral director Welsh Funeral Home

(b) Address 2008 Orleans St

(a) JAN 26 1945 Hunting for Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24 1945, at 7 1 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/19 1945 to 1/24 1945 and that I last saw him alive on 1/24 1945

Immediate cause of death	Duration
Cardio - resp. failure	
Due to ?	
Due to ?	
Other Conditions operation 1/21/45 - (Include pregnancy within 3 months of death)	
Date of operation 1/21/45	
Major findings of operation: Peranal prostatectomy	
of autopsy: ?	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Dr. I. M. Greenberg M. D.

Address Sinai Hosp. Date signed 1/24/45

150

G25145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. G25145

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hosp. 4 + 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1646 Montpelier St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Sennhenn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/8/1880

8. AGE: Years	Months	Days	If less than one day
64	4	16	hr. min.

9. Birthplace Pittsburgh, Pa. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business
FATHER 12. Name John Sickel
13. Birthplace Balto.
MOTHER 14. Maiden Name Vomina
15. Birthplace
16 (a) Informant Mrs Wm Ramsay
(b) Address 1646 Montpelier
17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1/26/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto.
18 (a) Funeral director Wilmot Funeral Home
(b) Address 2008 Orleans St
19 (a) (Date received by Registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24- 1945, at 2.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-23- 1945, to 1-24- 1945, and that I last saw h e Y alive on 1-24- 1945

Immediate cause of death Respiratory failure — Duration
Due to Pneumonia
Due to
Other Conditions Cardiovascular disease. over
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen C. Wooden M. D.
Address W. B. G. H. Date signed

625146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 N Milton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 N Milton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mollie S Wade

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife John Wade
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan 11 1865

8. AGE: Years 80 | Months — | Days 23 | If less than one day ....hr. ....min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Henry Kohrs
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Mrs Bernard Rohm
(b) Address 620 N Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Lloyd Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1945 at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to Jan 23 1945 and that I last saw h alive on Jan 23 1945

Immediate cause of death Diabetes Mellitus C. Coma — Duration 20 yrs
Due to also Chr. Generalized Arteriosclerosis — Duration " "
Due to — Duration
Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank J. Ayd M. D.
Address 2005 E. Monument St Date signed Jan 24/45

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625147 / 94a — Registered No. 62514?

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1821 E. 31st St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 ~~1831~~ E. 31st St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SAMUEL J. TEICHMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elsie Teichman
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Aug 31, 1890

8. AGE: Years	Months	Days	If less than one day
54	4	25	....hr. ....min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Laundry slaesman
11. Industry or business

FATHER 12. Name Dont Know
13. Birthplace "

MOTHER 14. Maiden Name Dont Know
15. Birthplace "

16 (a) Informant Mrs. Elsie Teichman
(b) Address 1821 E. 31st St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem City
Location

18 (a) Funeral director Wilson Funeral Home
(b) Address 2004 E. Oliver St

19 (a) (Date rec'd by registrar) (b) JAN 26 1945 Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25, 1945, at 3:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1945 to Jan 25 1945 and that I last saw him alive on Jan 24 1945

Immediate cause of death Coronary Thrombosis

Due to Other causes.

Due to Nervous Exhaustion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
16 hrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. J. Zimmerman M. D.
Address 8858 Harford Rd Date signed 1/25/45

VS 150

5148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G25148

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 927 Wilmer St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 Wilmer St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Woodard Arlodge.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Married

6 (b) Name of husband or wife William

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 9-24-1895

8. AGE: Years	Months	Days	If less than one day
49	4	1	hr. min.

9. Birthplace Howard Co. Md (Town, county, and state)

10. Usual Occupation Laundress.

11. Industry or business

FATHER
12. Name Singleton Woodard
13. Birthplace Md

MOTHER
14. Maiden Name Mary Rideout
15. Birthplace Md

16 (a) Informant Wm Arlodge
(b) Address 927 Wilmer Court.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-45 (month) (day) (year)
(c) Cemetery or crematory Halls Cemetery
Location Howard County Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna Ave

JAN 26 1945 (Date received by registrar) (b) Hunting for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1945, at 2.45 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1945 to Jan 25 1945, and that I last saw h[illegible] alive on Jan 24 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	2 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Stewart M. D.
Address 633 W Franklin St Date signed 1/26

X

625149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

625149
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital · D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3028 E 31st St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES R. RICHARDSON John R. Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Bertha
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) June 25, 1888

8. AGE: Years	Months	Days	If less than one day
~~56~~ (56)	6	29	hr. min.

9. Birthplace Church Creek, Dorchester Co., Md.
(Town, county, and state)
10. Usual Occupation Realtor
11. Industry or business

FATHER
12. Name Richard E. Richardson
13. Birthplace Church Creek, Md.

MOTHER
14. Maiden Name Mary L. Vickers
15. Birthplace Church Creek, Md

16 (a) Informant Mrs. Bertha Richardson
(b) Address 2028 E. 31st Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/45 (month) (day) (year)
(c) Cemetery or crematory Richardson Burial Ground
Location Church Creek, Md.

18 (a) Funeral director M. F. Sadoski & Sons
(b) Address 1808 Eastern Ave

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

JAN 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24 1945, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy-Inspection-Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h's death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Robert J. Lubowski M.D.
Medical Examiner.
Date signed 1/24/45

G25150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1780

G25150 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 741 E. FORT AVENUE
(c) Hospital or institution: 24-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1.0.0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 741 E. FORT AVENUE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM ZELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Sarah. Zell.

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 75 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Chicago, Ill. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry Zell.
13. Birthplace ?

MOTHER 14. Maiden Name Susan Potter.
15. Birthplace ?

16 (a) Informant Mrs. Edith McGowan
(b) Address 4611 Harcourt Rd.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 1/26/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location 3930 Frederick Ave.

18 (a) Funeral director Chas. F. Dill
(b) Address 1501 E. Fort Ave.

19 (a) (Date rec'd by registrar) JAN 26 1945 Registrar M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 23, 45 19..... at 5:25 P. M

21. I certify that I took charge of the remains described above, held an INSPECTION & ENQUIRY thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-23-45 5:45 P. M.
(b) Where did injury occur? 741 E. Fort Avenue.
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury COFFEE BOILED OVER + PUT FIRE OUT, BUT GAS WAS STILL ON.

23. Signature Howard J. Henderson M.D.
Medical Examiner.
Date signed JANUARY 24, 1945.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~65151~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V94a

Registered No. 65151

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address B&O Annex Bldg. -
(c) Hospital or institution: Lombard & Howard Sts.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. K 32 N. Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN WILLIAM HENRY

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-05-2515

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eva A. Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1887

8. AGE: Years	Months	Days	If less than one day
57	2	16	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Clerk
11. Industry or business B. & O. R. R.

FATHER
12. Name Edward V. Henry
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Sullivan
15. Birthplace Md.

16 (a) Informant Mrs. Eva A. Henry
(b) Address 432 N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Inspected by registrar) for Hunting for Williams, M.D. Registrar

JAN 26 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24- 1945, at 10 50 A.M.

21. I certify that I took charge of the remains described above, held an Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 1-24-45

X

25152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 13 1a

Registered No. G-25152

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Ridgehill Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Ridgehill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: BENJAMIN FRANKLIN CROFT

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Rosa L. Croft
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1874

8. AGE: Years	Months	Days	If less than one day
70	4	4	hr. min.

9. Birthplace: Carroll Co., Md. (Town, county, and state)
10. Usual Occupation: Carpenter
11. Industry or business: Self

FATHER
12. Name: Adam A. Croft
13. Birthplace: Carroll Co., Md.

MOTHER
14. Maiden Name: Barbara E. Boaz
15. Birthplace: Carroll Co., Md.

16 (a) Informant: Mrs. Rosa L. Croft
(b) Address: 2101 Ridgehill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/45 (month) (day) (year)
(c) Cemetery or crematory: Moreland Mem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md. Huntingdon / Williams Mt.

19 (a) (b) Registrar
(Date received by Registrar)

JAN 26 1945

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Jan. 23, 1945, at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1944 to Jan 23 1945. and that I last saw him alive on Jan 23 1945.

Immediate cause of death: Cardio-Renal Vascular Lesions — Duration: 2 yrs
Due to:
Due to:
Other Conditions: Asthma

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: Benj. Sanders, M. D.
Address 2128 W. Mount Date signed 1/28/45

625153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

625153
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 402 E. Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 E. Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anne Downes

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex
5. Color or race
6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John Downes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1858

8. AGE: Years 86 | Months 2 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas Hastings
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Cavey
15. Birthplace Ireland

16 (a) Informant Mrs. Mary Shannon
(b) Address 402 E. Biddle St

17 (a) Burial (b) Date thereof Jan. 27, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) JAN 26 1945 (Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24/45 19 , at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20/45 19 , to 1/24/45 19 , and that I last saw h. alive on 1/24/45 19

Immediate cause of death	Duration
Generalized Arteriosclerosis -	
Due to Senility -	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Mary Shannon
Address 402 E. Biddle St (Date signed) 1/25/45

G25154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G25154

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2210 Annapolis Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 Annapolis Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie M. Beach Iglehart.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced: widow.

6 (b) Name of husband or wife Herman Iglehart.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept ? 1878

8. AGE: Years 66 | Months 4 | Days | If less than one day hr. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Walter F. Beach.
(b) Address 2210 Annapolis Road.

17 (a) Burial. (b) Date thereof Jan 27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven.
Location Elmwood & Spaulding.

18 (a) Funeral director Elmwood & Spaulding
(b) Address 3615 Old Frederick Ave

19 JAN 26 1945 Hunting for Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24, 1945, at 11 30 M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22, 1945, to Jan 24 1945, and that I last saw her alive on Jan 24, 1945

Immediate cause of death Cerebral Hemmorrhage — Duration 2 days

Due to

Due to Arteriosclerosis — 3 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Selimpeo M. D.

Address 301 Annapolis Rd Date signed 1/25/45

625155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

625155 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1029 Valley St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 47

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Teofila Cwalina

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Boleslaw N.

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) July 26, 1881

8. AGE: Years 63 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name Michael Golanski
13. Birthplace Poland

MOTHER 14. Maiden Name Tekla Radziszewska
15. Birthplace Poland

16 (a) Informant Boleslaw N. Cwalina
(b) Address 1029 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/45 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location Cremation Hill Rd.

18 (a) Funeral director W. A. E. Hyde's Sons
(b) Address Lombard & Fremont Sts.

19 (a) (Date rec'd by registrar) JAN 30 1945 (b) Huntington Willi

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1945, at 11:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944, to Jan 25 1945, and that I last saw h[illegible] alive on Jan 25 1945.

Immediate cause of death Acute Cardiac dilatation — Duration 1 day 1/25/45

Due to Pulmonary Tuberculosis — 9/1944

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Rymer M.D.
Address 801 N Kenwood Ave Date signed 1/25/45

625156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625156 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2625 Maryland Ave
(c) Hospital or institution: –

(d) Length of stay in hospital or inst. (yrs., mos., or days) – 12
(e) Length of stay in Baltimore (yrs., mos., or days) –

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2625 Maryland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary C. Govin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75 74	–	–	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation
11. Industry or business Housework

FATHER
12. Name Peter O. Toole
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget McEnroe
15. Birthplace Ireland

16 (a) Informant Sharon Govin
(b) Address 2626 Maryland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Mary M Medford
(b) Address 501 E. 22nd St

JAN 26 1945 Huntington Williams, M.D. Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24/1945 at 6:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to 1/24/1945, and that I last saw h. E. alive on 1/24/1945.

Immediate cause of death	Duration
Myocardial Insufficiency	8 mos
Due to Pneumonitis	6 mos
Due to Hypertension	1 Yrs.
Other Conditions Generalized Arteriosclerosis	14 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. J. White M. D.
Address 532 E 22nd St Date signed 1/26/45

X Thos. J. White

625157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625157 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto-Md
(b) Street address 2219 Division ave.
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2219 Division st. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie F. Roberts.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C	Widowed

6 (b) Name of husband or wife Robert Roberts.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1861

8. AGE: Years	Months	Days	If less than one day
83	10		hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation None.
11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Virginia Dyson
(b) Address 2227 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. U. Nelson
(b) Address 1303 Pennsylvania Ave Baltimore, Md.

19 (a) Registered by (b) Registrar

JAN 26 1945

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24- 1945, at 10:22 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4- 1945, to 1-24- 1945, and that I last saw her alive on 1-24- 1945.

Immediate cause of death	Duration
Cardiac Failure	
Due to Myocarditis + arteriosclerosis.	?
Due to Pulmonary Congestion	3 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury

23. Signature Henry L. C. Hamm
Address 2340 Madison Ave Date signed 1-25-45 M. D.

F

65158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

Registered No. 65158

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1139 N. Mound Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William T. Smith

3 (b) If veteran, name war No

3 (c) Social Security Account No. None

4. Sex Male

5. Color [redacted]

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife None

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 8/4/1874

8. AGE: Years	Months	Days	If less than one day
70	5	18	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name Jefferson Smith
13. Birthplace Va.

MOTHER
14. Maiden Name Ida Brooks
15. Birthplace Va.

16 (a) Informant Mattie St. John (Sister)
(b) Address King & Queen Co. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. County, Md.

18 (a) Funeral director Chas H. Corbin
(b) Address 512 Carrollton Ave.

19 (a) JAN 26 1945 (Date received by Registrar) (b) Wilmington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 1945, at 11:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-22-45 at 16:30 M.
(b) Where did injury occur? Eutaw & Pratt Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work?
(d) Means of injury Pedestrian struck by street car

23. Signature Robert Le Gratten M.D. Medical Examiner.
Date signed Jan. 23 1945

25159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83D

Registered No. 25159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1225 Scott St
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1225 Scott st (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Edward . E. Ziegler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary E. Ziegler
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1/1/1861

8. AGE: Years	Months	Days	If less than one day
84	—	24	..... hr. ..... min.

9. Birthplace Unknown.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Un Known.
13. Birthplace Unknown.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Unknown.

16 (a) Informant Grace Hemniman
(b) Address 1225 Scott st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/45 (month) (day) (year)
(c) Cemetery or crematory London Park.
Location Fredpink ave.

18 (a) Funeral director Ambrose Fne.
(b) Address 414 N. Franklintown rd

19 JAN 26 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1945, at 11½ M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to Jan 25 1945.
and that I last saw h[illegible] alive on Jan 24 1945.

Immediate cause of death	Duration
Pneumonia	2 days
Due to Arteriosclerosis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul Schlegel M. D.
Address 731 Cromwell Date signed 1/25/45

VS 150

625160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 625160

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 Belgian Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Belgian Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence L. Evans

3 (b) If veteran, name war: 1st World War
3 (c) Social Security Account No.:

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret C.
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Aug 21, 1898

8. AGE: Years 46 | Months 5 | Days 3 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation mail carrier
11. Industry or business U. S. Mail

FATHER
12. Name James L Evans
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Annie L. Connolly
15. Birthplace Baltimore Md

16 (a) Informant Margaret C. Evans
(b) Address 711 Belgian Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29 / 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John C. Moran
(b) Address 3800 E Baltimore St

19 (Date received by registrar) JAN 26 1945 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1945, at 7:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1944 to Jan. 24 1945, and that I last saw him alive on Jan 24 1945.

Immediate cause of death: myocardial insufficiency — Duration: 1 day
Due to: coronary occlusion — 6 wo
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. C. Soldini MD
Address 4474 N. Kenwood Ave Date signed 1/26/45 M. D.

VS 180

625161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

625161
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2516 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2516 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbert Ballard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1919

8. AGE: Years 26 | Months - | Days 4 | If less than one day hr. min.

9. Birthplace Dale Island Md.
(Town, county and state)

10. Usual Occupation Assistant Store Manager

11. Industry or business

FATHER
12. Name Giles Hughes
13. Birthplace Md

MOTHER
14. Maiden Name Lurida Ballard
15. Birthplace Md

16 (a) Informant Lurida Ballard Young
(b) Address 2516 Madison Ave

17 (a) Removal (b) Date thereof Jan 27/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Dale Island Eastern Shore Md

18 (a) Funeral director Mrs. Robert O. Elliott & Sons
(b) Address 1129 N. Caroline St.

19 (a) (Date rec'd by registrar) (b) (Registrar)

JAN 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 1945, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/4 1944 to 1/24 1944, and that I last saw him alive on 1/20 1944

Immediate cause of death	Duration
Pulmonary Tuberculosis	unk.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Browne

Address 1500 E. Madison St. Date signed M. 1/25 D.

Rayner Browne X

625162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. 625162

1. PLACE OF DEATH:
(a) Baltimore City, ~~Maryland~~
(b) Street address BALTIMORE MD.
(c) Hospital or institution:
ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 E. LAFAYETTE AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FROUD EDWARD COOPER

3 (b) If veteran, name war

3 (c) Social Security Account No. 233-24-7600

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26 1912

8. AGE: Years	Months	Days	If less than one day
32	5	29	hr. min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Albert Cooper
13. Birthplace W. Va.

MOTHER
14. Maiden Name Lavrania Dunlap
15. Birthplace W. Va.

16 (a) Informant Aubrey Cooper
(b) Address W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave.

18 (a) Funeral director Martin J. Conroy
(b) Address 1102 Forrest St.

19 (a) JAN 26 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 23, 1945, at 5.45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Cardiac Failure

Due to

Other Conditions Acute Congestion + Edema of lungs. Edema of brain.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thomas J. Waldeis M.D.
Medical Examiner.
Date signed 1-24-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

625163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

625163 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 S. Washington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 61

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523 S. Washington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Julius De Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Anna De Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Adam De Martin
13. Birthplace Poland

MOTHER
14. Maiden Name Julia ?
15. Birthplace Poland

16 (a) Informant Mrs Anna De Martin
(b) Address 523 S. Washington Ave

17 (a) Burial (b) Date thereof Jan 27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John H. Webster
(b) Address 401 S. Chester street

19 (a) (b)
(Signature of undertaker) Registrar

JAN 26 1945

VS 154

Huntington Williams, M.D

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1944, to Jan 23 1945, and that I last saw h(e) alive on Jan 23 19 45.

Immediate cause of death	Duration
Bronchial Thrombosis	6 mths duration
Due to	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature B O'Kelly M. D.
Address 100 N Lemmon Ave Date signed Jan 24/45

X

G25164 V

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56 B

Registered No. G25164

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Balt. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3823 Foster Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Holdorf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife George Holdorf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/30/1906

8. AGE: Years	Months	Days	If less than one day
38	3	25	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name George Kalb
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna Bartell
15. Birthplace Baltimore, Md.

16 (a) Informant George C. Holdorf (hus)
(b) Address 3823 Foster Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 / 29/45 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Eastern Ave. Rd.

18 (a) Funeral director Lilly & Zeiler
(b) Address 403 S. Wolfe Street

JAN 26 1945 (Date rec'd by registrar) Lawrence Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 1945, at 11 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1945, to Jan. 25 1945, and that I last saw her alive on Jan. 25 1945.

Immediate cause of death Right sided heart failure — Duration

Due to Pulmonary Infarction

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Jan. 17, 1945

Major findings of operation: Intra-mural fibroids

of autopsy: Same as above

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul G. Lukatos M. D.

Address 1213 Light St. Date signed Jan. 26, 1945

625165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 625165

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 713 S.BOULDIN ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 dd
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 S.BOULDIN ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALBURGA FLEISCHMANN

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: CONRAD FLEISCHMANN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): MAR.30 1878

8. AGE: Years 66 | Months 9 | Days 25 | If less than one day: hr. min.

9. Birthplace: BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation: HOUSE WIFE

11. Industry or business: AT HOME

FATHER
12. Name: ALPHONSUS KISPERT
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: MARY ZISNER
15. Birthplace: BALTO.MD.

16 (a) Informant: CONRAD FLEISCHMANN(HUS.)
(b) Address: 713 S.BOULDIN ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN.27/45 (month) (day) (year)
(c) Cemetery or crematory: HOLY REDEEMER
Location: BELAIR ROAD

18 (a) Funeral director: Lilly and Zeiler INC.
(b) Address: 403 S.WOLFE ST.

19 JAN 26 1945 (Date received by local registrar) Huntington Williams M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN.24 1945, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1944, to Jan. 24 1945, and that I last saw her alive on Jan. 24 1945.

Immediate cause of death: Hypertensive cardiovascular disease.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Wm D Schmuck M. D.
Address 701 W. Kenwood Ave. Date signed 1/26/45.

VS 150

G25166

VIOLET E. CHRYSTAL G25166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 30 D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hosp - Mercy, Balto Md. | 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo - 13 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 life - 44 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town, limits, write RURAL and give town)
(d) Street No. 3439 Hickory Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Violet (A. E.) Chrystal

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife William Chrystal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1903.

8. AGE: Years 41 | Months 8 | Days 9. | If less than one day ... hr. ... min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Housf.

11. Industry or business

FATHER
12. Name Samuel Skinner
13. Birthplace Maryland.

MOTHER
14. Maiden Name Carrie Jeffery.
15. Birthplace Maryland.

16 (a) Informant Mrs Katie Jackson.
(b) Address 3439 Hickory Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 27-1945 (month) (day) (year)

(c) Cemetery or crematory St. Mary's (Hampden)
Location Baltimore, Md

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) JAN 26 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1945 at 7 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1944 to 1/24 1945 and that I last saw her alive on 1/24 1945

Immediate cause of death	Duration
Cardiac failure & Acute Pulm edema.	2-3 hrs.
Due to Luetic Aortitis.	
Due to Luetic C. V. D.	20 yrs?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Illegible M. D.
Address Mercy Hosp. Date signed 1/24/45

VS 150

As far as Dr. C. is concerned - I am quite sure patient was aware she had Luetic C.V.D. at time of Admission X F. H. MD.

625167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54B

625167
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1410 Union Avenue
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 Union Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Laura Elizabeth Cooney

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife James F. Cooney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22 1866

8. AGE: Years 78 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name James B. Mahaffey
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret A. Dinsmore
15. Birthplace Pennsylvania

16 (a) Informant Louis F. Mahaffey
(b) Address 1410 Union Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) JAN 26 1945 (Date received by registrar) (b) Registrar, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1945, at 12:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to Jan 26th 1945; and that I last saw her alive on Jan 26th 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration 6 Mo

Due to: Above

Due to: Above

Other Conditions: Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. A. Burgee

Address 36 N. Fulton Ave. Date signed 1-26-45

VS 150

r. Louis Hamburger
07 Eutaw Place 625168

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 625168
61 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3901 Greenway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3901 Greenway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick Milton Supplee

3 (b) If veteran, name war ----------
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elizabeth Griffith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2, 1876

8. AGE: Years	Months	Days	If less than one day
68	4	22	hr. min

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation Insurance Broker
11. Industry or business

FATHER
12. Name Alfred I. Supplee
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Katherine Buckley
15. Birthplace Balto. Md.

16 (a) Informant Elizabeth Griffith Supplee
(b) Address 3901 Greenway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 27, 1945 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave.

19 (a) JAN 26 1945 (Date rec'd by registrar) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1945, at 9.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1934 to Jany 24 1945 and that I last saw him alive on Jany 18 1945.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Arteriosclerotic heart disease Symptoms	6 yrs
Due to Generalized arteriosclerosis Hypertension	6 yrs
Other Conditions Diabetes Mellitus	21 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis P Hamburger M. D.
Address 1207 Eutaw Pl. Date signed 1-26-45

93D

SUBJECT TO APPROVAL OF MEDICAL EXAMINER:

BALTIMORE CITY HEALTH DEPARTMENT

625169 ✓ 625169 Registered No.

CERTIFICATE OF DEATH 1860

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 91 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1432 Gorsuch Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Salvatore Salafia or Salvatore Salafra

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Marian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1874

8. AGE: Years 71 | Months -0- | Days 23 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Salvatore Salafia
13. Birthplace Italy

MOTHER
14. Maiden Name Bracac or Bracca ?
15. Birthplace Italy

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Rd.

18 (a) Funeral director Joseph Farace Inc.
(b) Address 20 E Lexington St Balto

19 (a) JAN 26 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25, 1945, at 9:30AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11, 1944, to Jan. 25, 1945, and that I last saw him alive on Jan. 25, 1945.

Immediate cause of death Pneumonia — Duration 1 week
Uremia - Cardiac failure Coronary
Due to Benign Prostatic Hypertrophy 2 wks
Due to Broken Neck Lt. femur
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 12-2-44
Major findings of operation: Prostatic Hypertrophy -
of autopsy: Pneumonia -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/12
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 1-6-45 at ? P M
(c) Where did injury occur? Baltimore City Hosp (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital (Specify type of place) While at work? No
(e) Means of injury Fr. fem. left femur
23. Signature E J Feeley MD
Address BC H Date signed 1-26-45 M. D.

VS 150 SUBJECT TO APPROVAL OF MEDICAL EXAMINER: by - Thomas J. Waldron M.D.

625170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 625170

1-61a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 2 4 5 b
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1363 Andre St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Engram

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/25/45

8. AGE: Years | Months | Days | If less than one day: 14 hr. 20 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Ellsworth ~~Engram~~ Style
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Dorothy Engram
15. Birthplace Baltimore, Md

16 (a) Informant Father
(b) Address 1363 Andre St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 27/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W Ozmun
(b) Address 1930 Eastern Ave

19 (a) JAN 27 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26 1945 at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1945 to 1/26 1945 and that I last saw him alive on 1/26 1945.

Immediate cause of death: Complete Congenital Atelectasis of Both Lungs — Duration: Life (14 hours)

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Bilateral Congenital Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers, M. D.
Address Franklin Sq. Hosp. Date signed 1/27/45

X

(23171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 107

Registered No. 23171

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2106 Herbert St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 - 4

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2106 Herbert St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME CARL WILLIAM WODBY ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1944.

8. AGE: Years	Months	Days	If less than one day
	2	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Carl Wodby,
13. Birthplace Unknown.

MOTHER
14. Maiden Name Etta Whitehill,
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Etta Ashby,
(b) Address 2106 Herbert St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1.29.45. (month) (day) (year)
(c) Cemetery ~~or crematory~~ Oheb Shalom
Location Balto. Md.

18 (a) Funeral director Burial Association
(b) Address 1902 Eutaw Place.

JAN 27 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26th. 1945, at 9.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1945, to Jan 26 1945, and that I last saw h[illegible] alive on Jan 26 1945.

Immediate cause of death Pneumonia — Duration days

Due to

Due to

Other Conditions Malnutrition — over since birth

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place) 17
(e) Means of injury

23. Signature Harry Cushman M.D.

Address 1921 W. North Ave. Date signed 1/26/45

X

625172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 625172

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the ca... the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 s Calvert St
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks. 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5504 Craig Ave. Balto. 12
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME ~~Mary Bertha Kelly~~ Bertha Blanche Kelly

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Mr Henry David Kelly
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) May 10, 1903

8. AGE: Years	Months	Days	If less than one day
41	7	16	...hr. ...min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual Occupation Secretarial
11. Industry or business

FATHER
12. Name Mr. Douglas Taylor
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Kane
15. Birthplace Pennsylvania

16 (a) Informant Mrs Henry P. Kelly
(b) Address 5504 Craig Ave, Ba Ho. 12.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29, 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director John Brant's Sons
(b) Address Towson, Md.

19 (a) ... (b) ...
(Signature of registrar) Registrar

JAN 27 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26 1945 at 4 19 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14 1944, to Jan 26 1945, and that I last saw her alive on Jan. 26 1945

Immediate cause of death	Duration
Carcinomatosis with metastases to spine and liver.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1-11-44
Major findings of operation: Carcinoma of descending colon.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul S. Greer M. D.
Address Union Memorial Hospital Date signed 1-26-45

X

625173 BALTIMORE CITY HEALTH DEPARTMENT 625173

CERTIFICATE OF DEATH 48a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1414 E. Chase St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Mildred Jackson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Joseph Jackson (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-22-1899

8. AGE: Years 45 | Months 4 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Camp Holabird

FATHER
12. Name Nelson Harris
13. Birthplace Md

MOTHER
14. Maiden Name Henrietta ——
15. Birthplace Md

16 (a) Informant Joseph Jackson
(b) Address 1414 E. Chase

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. Co. Md.

18 (a) Funeral director James Astaire
(b) Address 142 W. Eutaw St

19 (a) (b) (Date received by registrar) Registrar

JAN 27 1945 Plumbing for Humane

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24 1945 at 7 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1943 to 1-24 1945 and that I last saw her alive on 1-22 1945

Immediate cause of death Carcinoma fossis — Duration

Due to Carcinoma-cervix — 13 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rayner Browne M.D.
Address 1 S W 1. Madison St Date signed 1/26/45

Rayner Browne X

625174

625174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway 6
(c) Hospital or institution: Church Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4d
(e) Length of stay in Baltimore (yrs., mos., or days) (entire years unknown)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Church Home & Hospital
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Miss Mary Hoofnagle

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1868

8. AGE: Years	Months	Days	If less than one day
76	10	6	..... hr. ..... min.

9. Birthplace Mt. Savage, Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name John F. Hoofnagle
13. Birthplace Baltimore

MOTHER
14. Maiden Name Doris Drake
15. Birthplace Frederick

16 (a) Informant Mrs Doris French
(b) Address 5520 Roanoke Ave

17 (a) Burial (b) Date thereof 1/27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto Md

19 (a) ..... (b) Huntington-Williams, Inc.
(Patrick J. Tickner) Registrar

JAN 27 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1945; at 8 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1945 to Jan 24 1945, and that I last saw her alive on Jan 24 1945

Immediate cause of death Carcinoma of the [redacted]
Duration 11 months

Due to [redacted]

Due to .....

Other Conditions [redacted]
Growing occlusion 5 mos. ago
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Marvin W. Davis, M. D.
Address Church Home Date signed 1-27-45

X

625175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625175 / 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1722 Bolton Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 1722 Bolton Street (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Margaret Harrison

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Harry W. Harrison

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1872

8. AGE: Years	Months	Days	If less than one day
72	4	4	hr. min.

9. Birthplace Harrisonville, Balto. Co., Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George Bailey
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Sarah Fite
15. Birthplace

16 (a) Informant Mrs. W. G. Bailey
(b) Address Route #5 Box 21, Dogwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/45 (month) (day) (year)
(c) Cemetery or crematory Ward's Chapel
Location Liberty Rd.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 29 10 PM (Date rec'd by state reg.) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-25- 1945, at 12:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Knedler M.D.
Medical Examiner.
Date signed 1-25-45

625176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. 625176

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette and John Sts.
(c) Hospital or institution:
Hospital for the Women of Maryland 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 dys

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2213 Roslyn Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Davis Inman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Married

6 (b) Name of husband or wife William H. Inman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1879

8. AGE: Years	Months	Days	If less than one day
65	6	29	hr. min.

9. Birthplace Yorkshire, England
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Miles Davis
13. Birthplace England

MOTHER
14. Maiden Name — Merrick
15. Birthplace England

16 (a) Informant Mrs. Lewis Fox
(b) Address Gibson Island, Maryland

17 (a) Burial (b) Date thereof 1/27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Wrgid Ridge Cem.
Location Pikesville Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto. Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

VS Form JAN 27 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25, 1945, at 3:51 PM

21. I certify that death occurred on the date above stated; that I attended deceased from December 31, 1944, to January 25, 1945, and that I last saw her alive on January 25, 1945.

Immediate cause of death	Duration
Adenocarcinomatosis generalized	
Primary site unknown	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Confirms above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Sprunt M. D.
Address Women's Hospital Date signed 1-25-45

X

625177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625177 / 93D

Registered No. 625177

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully compiled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 408 E. Biddle St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 73yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A. Hennessy

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 7, 1871

8. AGE: Years	Months	Days	If less than one day
73	1	18	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Dressmaker
11. Industry or business Slusch Bros.

FATHER
12. Name John Hennessy
13. Birthplace Ireland

MOTHER
14. Maiden Name Alice Lyons
15. Birthplace Ireland

16 (a) Informant Miss Sarah E. Hennessy
(b) Address 408 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29, 1945 (month) (day) (year)
(c) Cemetery or crematory St. Vincent Cemetery
Location Near Gilfillan Park

18 (a) Funeral director Edwin W. Conkling & Son
(b) Address 924 E. Lager St.

19 (a) (Date received by local registrar) JAN 27 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26, 1945 at 10:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1944, to Jan 25 1945, and that I last saw her alive on Jan 24 1945.

Immediate cause of death	Duration
Chr. Myocarditis with Bronchopneumonia	yrs
Due to Arteriosclerosis Generalized	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William A. Gaughe
Address 10 E Biddle Date signed 1/26/45

X

G25178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G25178

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3505 Taney Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-20
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3505 Taney Road. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JULIUS JACOBY.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of ~~husband or~~ wife Rosa Jacoby.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1860

8. AGE: Years	Months	Days	If less than one day
84	4	21	hr. min.

9. Birthplace Germany. (Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business

FATHER
12. Name Nathan Jacobi.
13. Birthplace Germany.

MOTHER
14. Maiden Name Josephine ?
15. Birthplace Germany.

16 (a) Informant Mrs. Rosa Jacoby.
(b) Address 3505 Taney Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1.29.45. (month) (day) (year)
(c) Cemetery or ~~crematory~~ Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sonneborn's Son
(b) Address 1902 Eutaw Place.

19 (a) JAN 27 1945 (Date received by Registrar) (b) Hunting for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26th. 1945. at AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1945 to Jan 26 1945. and that I last saw h.i.m alive on Jan 25 1945.

Immediate cause of death Coronary thrombosis — Duration 1 hour
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan Bernstein M. D.
Address 1039 N. Calvert St Date signed 1/26/45

X

625179 Ocie Shorter 625179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 N. Fairmount Av.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 + 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 N. Fairmount Av.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ocie Shorter

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Edith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Shorter
13. Birthplace Hartford Co., Md.

MOTHER
14. Maiden Name Elizabeth Butler
15. Birthplace A. A. Co., Md.

16 (a) Informant Mrs. Edith Shorter
(b) Address 706 N. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-'45. (month) (day) (year)
(c) Cemetery or crematory National
Location

18 (a) Funeral director Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (b) Registrar
(Date received by registrar)
JAN 27 1945
VS 10c

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1945 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1945 to Jan 25 1945, and that I last saw h. alive on Jan 25 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Hypertension and Cardiovascular Renal Disease	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Redding M.D.
Address 426 N. Johns St. Date signed 1/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G25180
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5638 Belair Road
(c) Hospital or institution:
26-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5638 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha M.Baker

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Harry L.Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.24.1889

8. AGE: Years	Months	Days	If less than one day
55	11	1	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name George P.Phillips
13. Birthplace Balto.Md.

MOTHER
14. Maiden Name Emma C.Sheets
15. Birthplace Balto.Md.

16 (a) Informant Mr.Harry L.Baker
(b) Address 5638 Belair Road

17 (a) Burial (b) Date thereof Jan.30/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto.Md.

18 (a) Funeral director Philip Sterling Sons
(b) Address 2024 Orleans St.

19 (a) (Date) JAN 27 1945 (b) Registrar Huntington Hollins M.D.

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan.25/45 19 , at 9A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24 1944 to 1/25 1945.
and that I last saw h alive on 1/24/ 1945

Immediate cause of death
Cachexia -
Due to Carcinoma of Pancreas
Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation June 1944
Major findings of operation
Ca of Pancreas
of autopsy:

Duration
2 Mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Dora Barden
Address 1512 E Northave Date signed 1/26/45 A. D.

X

625181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

625181 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 CLARKSON ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE MD (If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 CLARKSON ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERMAN MEIXNER

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-05-8484

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife ANGELINE MEIXNER

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) NOV 8-1884

8. AGE: Years 60 | Months 2 | Days 16 | If less than one day ..... hr. ..... min.

9. Birthplace GERMANY. (Town, county, and state)

10. Usual Occupation CLERK.

11. Industry or business RADFORD + SANDERS INC

FATHER
12. Name CHARLES MEIXNER
13. Birthplace GERMANY

MOTHER
14. Maiden Name ROSA ?
15. Birthplace GERMANY

16 (a) Informant ANGELINE MEIXNER
(b) Address 1317 CLARKSON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 29-45 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BALTO MD

18 (a) Funeral director Bernard C. Harlow
(b) Address 121 E West St

19 (a) JAN 27 1945 (Date received by registrar) (b) Huntingtown Williamsport, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 24 1945 at 11 10P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9 1944 to Jan 24 1945 and that I last saw h alive on Jan 24 1945

Immediate cause of death Chronic Endocarditis — Duration 2 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Inv

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Metcalf M. D.

Address 1279 Fulham N Date signed 1/26/45

X

4677396 25182

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

625182
Registered No.

30C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 & N. Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Pistorio

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Kathleen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-4-95

8. AGE: Years	Months	Days	If less than one day
49.	10	21	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Fruit dealer
11. Industry or business

FATHER
12. Name Leo Pistorio
13. Birthplace Md.

MOTHER
14. Maiden Name Augustino ? ?
15. Birthplace Italy

16 (a) Informant Parents
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) burial (b) Date thereof Jan. 29/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) (Date received by Registrar) JAN 27 1945 (b) Registrar

Waiting for Affidavit

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan-25- 1945 at 8.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-23 1945 to Jan-25 1945, and that I last saw him alive on Jan 25 1945

Immediate cause of death cerebral thrombosis collapse — Duration 1 week

Due to Hypertension c-Vdisease & chronic enlargement of pancreas — 4 yrs

Due to CNS syphilis / Paralytic suicide / Cachexia, ? myocardial infarct

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham Zenecin
Address Johns Hopkins Hospital Date signed 1-28-45

X

G-5183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

178a

G-5183 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James H. Cassran

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-8065

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
C	M	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1- 1873

8. AGE: Years	Months	Days	If less than one day
72		24	hr. min.

9. Birthplace St Marys Co, Md (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name George Cassran

13. Birthplace Md

MOTHER 14. Maiden Name Amanda Barlow

15. Birthplace Md

16 (a) Informant Frances Smith

(b) Address 1920 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-1945 (month) (day) (year)

(c) Cemetery or crematory St Peters Cemetery

Location Balto City

18 (a) Funeral director Geo T. G. Gibson

(b) Address 1735 Druid Hill Ave

19 (a) JAN 27 1945 (Date received by registrar) (b) Huntington Hill Date, P.M. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24 1945, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH asphyxiation due to carbon monoxide poisoning - accidental

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 1-24-45 at 2 P.M.

(b) Where did injury occur? 1707 Madison Avenue

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no

(d) Means of injury Inhalation of illuminating gas

23. Signature Walter P. Gibson M.D. Medical Examiner.

Date signed 1/24/45

625184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

625184 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 E. Federal St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 E. Federal St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Eulotta Cimino

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife Andrew Cimino
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23. 1871

8. AGE: Years	Months	Days	If less than one day
73	8	3	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER | FATHER
12. Name Joseph Eulotta
13. Birthplace Italy
14. Maiden Name Maria Danna
15. Birthplace Italy

16 (a) Informant Husband Andrew Cimino
(b) Address 1815 E. Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29th 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belgin Road

18 (a) Funeral director Frank V. Pistone
(b) Address 2218 E. Balto. St

JAN 27 1945 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26th 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6 1945, to 1-26 1945, and that I last saw h[illegible] alive on 1-24 1945.

Immediate cause of death Hypostatic Pneumonia. Duration 2 weeks

Due to Chronic interstitial nephritis & hypertension 5 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. D. Emarco M.D.
Address Medical arts Bldg Date signed

65185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 65185

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Community Hospital 18

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 N. Fremont Ave apt. 8 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Malvern Green

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Lucy Green
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-1892

8. AGE: Years	Months	Days	If less than one day
52	0	29	hr. min.

9. Birthplace Jackson, South Carolina (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Green
13. Birthplace SC

MOTHER
14. Maiden Name Hanna ?
15. Birthplace S C.

16 (a) Informant Lucy Green
(b) Address 204 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brent Rd

19 (a) JAN 27 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1945, at 1:45 P. M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 1-25-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~25186~~ BALTIMORE CITY HEALTH DEPARTMENT 93 D Registered No. 65186

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ Hosp.
(c) Hospital or institution Redwood & Green St. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 das.
(e) Length of stay in Baltimore (yrs., mos., or days) Lifs ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltomore
(c) City or town Baltomore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 65 7 West Baue St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Wright.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	Widowed

6 (b) Name of husband or wife not given

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Nelson Roy
13. Birthplace Md.

MOTHER
14. Maiden Name Isabel Scott
15. Birthplace City.

16 (a) Informant Elvera W Colman
(b) Address 635 N pace St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28th 1945 (Month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Guy C Nelson

(b) Address 1000 Brantley

19 (a) (Date rec'd by registrar) (b) Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1945 at 9 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1945 to Jan 23 1945 and that I last saw her alive on Jan 23 1945

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerosis	
Due to Hypertension	
Other Conditions Cardio Vascular Disease	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Tankhouser M.D. M. D.

Address Redwood & Green St Date signed 1-24-45

VS 150

625187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No. 625187

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) ~~Hospital~~ or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 3770 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel McKay

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mrs. McKay

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-16-02

8. AGE: Years 42 | Months 10 | Days 9 | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business Shuf Repair

FATHER
12. Name Robt McKay
13. Birthplace South Carolina

MOTHER
14. Maiden Name Aggie Seymour
15. Birthplace South Carolina

16 (a) Informant Mrs McKay
(b) Address 3770 W Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/45 (month) (day) (year)

(c) Cemetery or crematory Location Cheraw S.C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Pennsylvania Ave

19 (a) (b)
Signature of registrar JAN 27 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25 1945 at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/13 1945 to 1/25 1945 and that I last saw h[illegible] alive on 1/25 1945

Immediate cause of death: Respiratory Failure — Duration: 3 Days

Due to: Pregnancy Ectopic Tubal

Due to: Secondary anemia from C. A. Bladder

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles F. O'Donnell, M.D.
Address Mercy Hosp Date signed 1/26/45

625138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625188

Registered No. 25188

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2220 Cedley St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2220 Cedley Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John E. Cooke

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-8959

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife late Lillie M Cooke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 17, 1882.

8. AGE: Years	Months	Days	If less than one day
62	2	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county and state)
10. Usual Occupation Sheet Metal worker
11. Industry or business Crook Sheet Metal Co.

FATHER
12. Name Eugene P. Cooke
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. John L. Groener
(b) Address 2220 Cedley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/45
(month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Edgewood & Edmondson Ave

18 (a) Funeral director John J. Cowan Sons
(b) Address 904 N. Fulton Ave

JAN 28 1945 (b) Huntington Williams, M.D.
(by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26th 1945, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 19 45, to Jan 26 19 45, and that I last saw h[illegible] alive on Jan 25 1945.

Immediate cause of death Cardiac Failure — Duration 2 weeks

Due to Myocarditis - Chronic — Duration 6 months

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Underhill M. D.

Address 821 Arlington Ave Date signed 1/26/45

625189 BALTIMORE CITY HEALTH DEPARTMENT 625189
CERTIFICATE OF DEATH 1860 Registered No. 25189

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hosp - ✓
(d) Length of stay in hospital or inst. (yrs., mos., days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3210 Dudley Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Margaret Mehling
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: George J. Mehling
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8/7/69
8. AGE: Years 75 | Months 6 | Days 19 | If less than one day hr. min.
9. Birthplace Baltimore, Md (Town, County, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace

16 (a) Informant Mrs. Joseph L. Fischer
(b) Address 3210 Dudley Avenue
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore
18 (a) Funeral director Leopard & Kuck
(b) Address 5305 Harford Road
19 (a) Filed 28 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH 1/26 1945 at 12:15 M
21. I certify that death occurred on the date above stated; that I attended deceased from 1/17 1945 to 1/26 1945 and that I last saw her alive on 1/26 1945.
Immediate cause of death Respiratory Failure — Duration
Due to Cerebral Thrombosis
Due to Arterio Sclerosis
Other Conditions Diabetes Mellitus Hypostatic Pneumonia - and (Include pregnancy within 3 months of death)
Date of operation Intratrochanteric
Major findings of operation: fracture of left femur,
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident.
(b) Date of occurrence January 17 1945 at 3 P. M
(c) Where did injury occur? 3210 Dudley Avenue. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No. slipped on rug in livingroom
(e) Means of injury fell to floor
23. Signature Edmond Scarone
Address St. Josephs Date signed 1/26/45

VS 150 For B. H. B. McNally, by Thomas J. Meeks, M.D.

G25190

BALTIMORE CITY HEALTH DEPARTMENT G25190

CERTIFICATE OF DEATH 83B

Registered No. 25190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Richwood ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Erma Gracie Herbst

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George Herbst.
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) May 7 1895

8. AGE: Years	Months	Days	If less than one day
49	10	19	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John F Baumbaum
13. Birthplace Md.

MOTHER
14. Maiden Name Liza Bohn Bahn
15. Birthplace Germany.

16 (a) Informant Mrs. George H. Herbst
(b) Address 702 Richwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-45 (month) (day) (year)
(c) Cemetery or crematory Union Cemetery
Location Glen Rock - Pa.

18 (a) Funeral director Leonard J. Rusk
(b) Address 5305 Harford Rd.

19 (a) [illegible] 1945 (Date rec'd by registrar) (b) [illegible] Hyattsville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26 1945, at 11 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13 1944 to 1-26 1945 and that I last saw h[illegible] alive on 1-26 1945.

Immediate cause of death Embolism to brain.

Due to Deep Plain Thrombosis of both iliac arteries,

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George Brunch M. D.
Address J.H.H. Date signed 1-26-45

VS 150

625191 BALTIMORE CITY HEALTH DEPARTMENT 625191

CERTIFICATE OF DEATH 93c Registered No. 2591

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 minutes yes
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2325 Hartford Rd (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Rev. Herbert A. Frederick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18-1905

8. AGE: Years	Months	Days	If less than one day
39	9	8	.....hr. .....min.

9. Birthplace Middletown - Pa (Town, county, and state)
10. Usual Occupation clergyman
11. Industry or business

FATHER
12. Name John A. Frederick
13. Birthplace

MOTHER
14. Maiden Name Mary F. Sindall
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs. Lillian M. Hamel
(b) Address 3152 Texas Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5345 Harford Rd Phone Govt Hill 4444, Md

19 (a) JAN 28 1945 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26 1945, at 11 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to h.c. death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rheumatic C.V disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Charles L. Schranck M.D. Medical Examiner.
Date signed 1/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Stevens
2878 Harford G25192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G25192
Registered No. 13 a 25192

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2810 Strathmore Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2810 Strathmore Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie B. Laur

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife John J. Laur
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1861

8. AGE: Years	Months	Days	If less than one day
83	7	21	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name George Lieb
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Mrs. Barbara Lorenz
(b) Address 2810 Strathmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) Date of registration JAN 28 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1945, at 4 15 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1945 to June 26 1945, and that I last saw her alive on June 25 1945.

Immediate cause of death	Duration
Bronco Pneumonia	3 d.
Cerebral Hemorrhage	7 d.
Due to Arterio Sclerosis	24 yrs
Due to Chronic Interstitial Nephritis	36 yrs
Other Conditions	

(include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E G a Stevens. M. D.
Address 2878 Harford Rd Date signed 1-27-45

VS 150

625193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

625193
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hosp. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6106 Fort View Ave
(If rural give location) Balto 24
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Jacqueline Opszenthowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26-1944

8. AGE: Years	Months	Days	If less than one day
	7	27	.....hr. .....min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Peter Opszenthowski
13. Birthplace Baltic Co. Md

MOTHER
14. Maiden Name Betty G. Hafer
15. Birthplace Pitts. Pa.

16 (a) Informant Parents
(b) Address 6106 Fort View Ave

17 (a) Burial (b) Date thereof Jan 27-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Fremont & Hill Rds.
18 (a) Funeral director John B Connolly
(b) Address 418 Eastern Ave Conv

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1945, at 11.30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s. death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage, traumatic

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 26/6
(a) Date of injury January 23, 1945 8:30 P.M.
(b) Where did injury occur? 6106 Fort View Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? At home. While at work? No
(d) Means of injury Slipped & fell into bathtub

23. Signature Robert L. Gratton M.D.
Medical Examiner.
Date signed 1-24-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95C

625194

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2149 Vine Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2149 Vine Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Phillip Zoeller

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1892

8. AGE: Years	Months	Days	If less than one day
52	2	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Invalid
11. Industry or business

FATHER
12. Name Edward N. Zoeller
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Emily
15. Birthplace Maryland

16 (a) Informant Mrs. Mary Zoeller
(b) Address 2149 Vine Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director Geo. H. Eckard
(b) Address 341 of Frederick Ave

19 (a) JAN 28 1945 (Date rec'd by registrar) (b) Lemington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27 1945, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1945 to 1/27 1945 and that I last saw him alive on 1/26 1945.

Immediate cause of death: Cardiac decompensation — Duration: 3 days
Due to: Hypertension
Due to:
Other Conditions: Anemia — 50 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Chas. D. Aisquith M. D.
Address 2145 W. Balto Date signed 1/27/45

VS 150

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH 625195 — 937 6 625195

County ..... Registration District No. .....

Village or City Brooklyn No. 1 St., Ward

(If death occurred in hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... How long in U.S. if of foreign birth? ..... yrs. ..... mos. ..... da.

2. FULL NAME Francis A. Burris Sr

(a) Residence: No. 3561 6th st St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Wells

6. DATE OF BIRTH (month, day, and year) June 26 1869

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76		2	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. B & O R.R.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Retired

10. Date deceased last worked at this occupation (month and year) Before 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) (State or country) .....

MOTHER

15. MAIDEN NAME .....

16. BIRTHPLACE (city or town) Unknown (State or country)

17. INFORMANT Margaret Burris

(Address) 3561 6th St

18. BURIAL, CREMATION, OR REMOVAL Knoxville Md. Date Jan 31, 1945

19. UNDERTAKER C. H. Feete & Bro

(Address) Brunswick Md

20. FILED JAN 28 1945 I. Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan (Month) 28 (Day) 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 1/26, 1945, to 1/28, 1945

I last saw him alive on 1/27/45, 1945; death is said to have occurred on the date stated above, at ..... m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Heart failure due to hypostatic congestion disease	
Other Contributory Causes of Importance: Cerebral sclerosis	over

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Dunnally Patton M. D.

(Address) 203 Catoctin Ave

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

X

467797 625196 BALTIMORE CITY HEALTH DEPARTMENT ✓ 625196

CERTIFICATE OF DEATH 46M Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3712 Hudson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Christopher E. Niemann

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-22-9111

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Widowed

6 (b) Name of husband or wife Wilhelmina M. Niemann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-18-67

8. AGE: Years	Months	Days	If less than one day
77	11	8	hr. min.

9. Birthplace Germany. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Niemann
13. Birthplace Germany.

MOTHER
14. Maiden Name Christine ?
15. Birthplace Germany.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-45. (month) (day) (year)
(c) Cemetery ~~or crematory~~ SACRED HEART CEM.
Location GERMAN HILL RD. BALTO. CO. MD.

18 (a) Funeral director Charles H. Zeiler
(b) Address 3605 FAIT AVE.

19 (a) (Date rec'd by registrar) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1945, at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24 1945, to Jan 26 1945. and that I last saw him alive on Jan. 26 1945.

	Duration
Immediate cause of death Uremia	
? Transfusion reaction	
Due to ? Pernicious anemia	? 4 yrs
Due to ? Cancerous ulcer of stomach with metastasis	? 4 yrs
Other Conditions Generalized arteriosclerosis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Kenesson
Address Johns Hopkins Hospital Date signed 1-26-45 M. D.

625197 625197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 10

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hasford Road
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore City (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1106 N Central Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza Mayo

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-?-40

8. AGE: Years 4 | Months 1 | Days | If less than one day: hr. min.

9. Birthplace [redacted] Virginia (Town, county, and state)
10. Usual Occupation child
11. Industry or business —

FATHER
12. Name James Mayo
13. Birthplace Virginia

MOTHER
14. Maiden Name Lucinda Henry
15. Birthplace Virginia

16 (a) Informant Sydenham Hosp. Records
(b) Address Hasford Road

17 (a) Burial, cremation, or removal
(b) Date thereof Jan. 27, 1945 (month) (day) (year)
(c) Cemetery or crematory
Location La Grange Va.

18 (a) Funeral director Robert L. Coquet
(b) Address Box 2. Carlisle Pa

19 (a) (b) Huntington Williams Registrar
(Date received by registrar)

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24 1945, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17 1945, to 1-24 1945, and that I last saw h[illegible] alive on 1-24 1945

Immediate cause of death	Duration
a Cardiac Failure	
Due to b phlythesia & myocardial insufficient	2 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clifton W. Jones Jr MD M. D.
Address Sydenham Hosp Date signed 1-24-45

X

G25198 BALTIMORE CITY HEALTH DEPARTMENT G25198

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2024 E Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2024 E Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abe Epstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rosie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1885

8. AGE: Years	Months	Days	If less than one day
59	8	11	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Cigar Manufacturing

FATHER
12. Name Meyer Epstein
13. Birthplace Russia

MOTHER
14. Maiden Name Ida ?
15. Birthplace Russia

16 (a) Informant Rosie Epstein
(b) Address 2024 E Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan, 28, 1945 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 28 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1945 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1944 to Jan 26 1945, and that I last saw h[illegible] alive on Jan 1945

Immediate cause of death	Duration
Coronary thrombosis	1 hour
Due to H Tension	5 years
Due to Arteriosclerosis	5 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alan Bernstein M. D.
Address 1039 N Calvert St Date signed 1/26/45

X

G25199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G25199

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1508 N. Spring Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
99
(d) Street No. 1508 N. Spring Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry G. Hagner

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 217-03-6380

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marie Kachele
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) February 6, 1902

8. AGE: Years	Months	Days	If less than one day
42	11	20	hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Canton Railway

FATHER
12. Name Anthony Hagner
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Anna Vomastek
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Marie Hagner
(b) Address 1508 N. Spring Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31, 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto; Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

JAN 28 1945
19 (a) Huntington Hillcrest, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1941 to 1/26 1945, and that I last saw h[illegible] alive on 1/20 1945

Immediate cause of death Coronary thrombosis — Duration 0

Due to Coronary arting disease — Duration Any Yrs

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hubert G. Wagenmire M. D.
Address 1445 N Gay St. Date signed

625200 625200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 Llewellyn Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Burdette. (Virginia Burdett)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Arthur Burdett

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) 12-4-1884

8. AGE: Years 60 | Months 1 | Days 21 | If less than one day ### hrs. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name ######## Taylor (Henry)
13. Birthplace Md.

MOTHER
14. Maiden Name ### Morse (Euphenia)
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29, 1945 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location E. North Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (Date received by registrar) Huntington Williams M.D. Registrar

JAN 28 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 - 1945 2:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24 1945 to Jan. 25 1945, and that I last saw ... alive on Jan. 25 - 1945.

Immediate cause of death cardiac failure — Duration

Due to A.S. ht. dis. myo. infarc., BBB

Due to

Other Conditions Obesity Diabetes Cadaveris.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. M. Hellberg M. D.
Address JHH. Date signed 1-25

93D

G25201

HEALTH DEPARTMENT—CITY OF BALTIMORE

G25201

CERTIFICATE OF DEATH

1937

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4402 Forest Park Ave. Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 9 yrs. 1 mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

2. FULL NAME Gershin Calman Tofs

If U. S. Veteran specify WAR

(a) Residence: No. 4402 Forest Park Ave St. Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. Color or Race: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Fannie Levine Tofs

6. DATE OF BIRTH (month, day, year): April 15, 1872

7. AGE: Years 72 | Months 9 | Days 12 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Tailor

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: Clothing

10. Date deceased last worked at this occupation (month and year): 12-44

11. Total time (years) spent in this occupation: 40yr

12. BIRTHPLACE (city or town) (State or country): Lithuania

FATHER

13. NAME: Isaac Tof

14. BIRTHPLACE (city or town) (State or country): Lithuania

MOTHER

15. MAIDEN NAME: Sarah —

16. BIRTHPLACE (city or town) (State or country): Russia

17. INFORMANT: Irving Tippens

(Address) 4402 Forest Park Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Washington Rd Date 1-28 1945

19. UNDERTAKER: Jack Lewis Inc

(Address) 2100 Eutaw Pl

Filed JAN 28 1945 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): Jan. 27, 45

22. I HEREBY CERTIFY, That I attended deceased from Jan. 20, 45 to Jan. 27, 1945

I last saw him alive on Jan. 27, 1945 Death is said to have occurred on the date stated above, at 10:05 P.M.

The principal cause of death and related causes of importance were as follows:

	Duration of disease
Arteriosclerosis	1 yr
Chr. myocarditis	1 yr
Other contributory causes of importance: Edema Uremia	4/23/18

Was an operation performed? No Date of

For what disease or injury?

Name of operation Date of

What test confirmed diagnosis? Clin. data Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Sol Schlossberg M. D.

(Address) 4402 Forest Park Ave Baltimore

X

information should be carefully supplied. AGE, state CAUSE OF DEATH in plain terms, so that OCCUPATION is very important. See instructions on back of certificate.

G25202 Mad 5715 ✓ G25202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 955 N. May St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 955 N. May St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thresesa Eisenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife dead

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant Samuel Eisenberg
(b) Address 1613 Munsey Bldg.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Reinstein
(b) Address 1409 E. Balto. St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26-45 19 , at 9 20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14 1944 to 1/26 1945, and that I last saw h alive on 1/25 1945.

Immediate cause of death Senelety
Due to Ruptured lung
Due to Diabetes
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation No
Major findings of operation:
of autopsy: No

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident. Contributory
(b) Date of occurrence November 14, 1944 at P. M.
(c) Where did injury occur? 955 N. GAY ST. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME. While at work? No.
(Specify type of place)
(e) Means of injury TRIPPED OVER A CHAIR AT HOME AND FELL TO FLOOR.

23. Signature [signature] M. D.
Address 2309 Cust Ave Date signed 1/28/45

JAN 28 1945 For A.C.J. Zulewski, by Howard J. Mercer, M.D.

625203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

625203 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospt
(c) Hospital or institution: Monument St
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2026 Paxton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME COHEN, BERTHA

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Philip M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Israel Hoff
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-45 (month) (day) (year)
(c) Cemetery or crematory Wmden Mill Rd.
Location Wmden Mill Rd.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/28 1945, at 5 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19 1945 to 1-28 1945, and that I last saw her alive on 1/28 1945.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Hart Failure	
Due to	over
Other Conditions Coma	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elmer Hoffman, M. D.
Address Sinai Hospital Date signed 1/28/45

G25204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1178

G25204 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Sinai Hos.

(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3213 Leighton Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Tillie Goldberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Russia

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Not Known

13. Birthplace Russ.

MOTHER 14. Maiden Name Not Known

15. Birthplace Russ.

16 (a) Informant Hospital Records

(b) Address

17 (a) Burial (b) Date thereof 1-29-45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Rosedale

18 (a) Funeral director Jack Lewis Inc.

(b) Address 2100 Eutaw Pl.

19 (a) (b) Registrar

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27- 1945, at 8 38 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1945 to 1-27-1945 and that I last saw her alive on 1-27-1945

Immediate cause of death Peritonitis

	Duration

Due to Perforated duodenal ulcer & peritonitis,

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1-26-45-1:00 A.M.

Major findings of operation: Perforated duodenal ulcer & peritonitis

of autopsy: Same - ulcer closed

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature David S. Gordon M.D.

Address Sinai Hospital Date signed 1-28-45

G25205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G25205

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4132 Parkside Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4132 Parkside Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Matter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Geo. G. Matter

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Sept 2-1875

8. AGE: Years 69 | Months 4 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Peter J Miller
13. Birthplace Md

MOTHER
14. Maiden Name Barbara Koenig
15. Birthplace Hohenmocksville Germany

16 (a) Informant George Matter
(b) Address 4132 Parkside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 30 45 (month, day, year)

(c) Cemetery or crematory Immanuel Evangelical Lutheran
Location

18 (a) Funeral director George Schilling & Son
(b) Address 3624 Greenmount Ave.

19 (a) (Date rec'd by registrar) (b) JAN 28 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1945, at 12-10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945 to Jan 27 1945 and that I last saw h[illegible] alive on Jan 27 1945.

Immediate cause of death Icterus (Jaundice) — Duration 3 wks

Due to Carcinoma of Liver — 1 1/2 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harvey Beach M. D.
Address 700 E 23d St Date signed

Huntington Williams

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625206

BALTIMORE CITY HEALTH DEPARTMENT

625206

CERTIFICATE OF DEATH 937

Registered No. 625206

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3318 Rumley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3318 Rumley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F Potts

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 13 1861

8. AGE: Years	Months	Days	If less than one day
83	11	10	hr. min.

9. Birthplace Balto Co Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Frederick Potts
13. Birthplace Balto Co

MOTHER
14. Maiden Name Mahanna
15. Birthplace Baltimore

16 (a) Informant Mary Potts
(b) Address 3318 Rumley Ave

17 (a) Burial (b) Date thereof 1/29/45
(Burial, ~~cremation or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location a. a. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) JAN 28 1945 (b) Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1945 at 2:56 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1945 to Jan 23 1945, and that I last saw him alive on Jan 25 1945.

Immediate cause of death Myocardial Degeneration — Duration

Due to Arterio-Sclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Lubin M. D.
Address 320 Cathedral St Date signed 1/26/45

Lubin

VS 150

625207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 10

625207 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 774 McHenry St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Wayne G. Fenwicke (FENWICK)
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10 1943

8. AGE: Years	Months	Days	If less than one day
1	4	17	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Thomas W. Fenwick
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Lawson Elliott
15. Birthplace Solomons Md.

16 (a) Informant Mrs. Lawson Fenwick
(b) Address 774 McHenry St.

17 (a) Removal (b) Date thereof 1-29-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Solomons Island
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JAN 28 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27- 1945 at 1 00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26- 1945 to 1-27 1945 and that I last saw him alive on 1-27 1945

Immediate cause of death Toxhead
Obstruction
Due to Laryngo Tracheal Bronchitis

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation 1-26-45

Major findings of operation: ac. Obstruction 2° Trachea

of autopsy —

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Thurston D. Bee M. D.
Address Mercy Hosp. Date signed 1-27-45

625208 BALTIMORE CITY HEALTH DEPARTMENT Registered No. 6208
CERTIFICATE OF DEATH 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1044 W. Overlea Avenue
(If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary B. Farmer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26 1876

8. AGE: Years	Months	Days	If less than one day hr.	min.
69	3	-		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired School Teacher
11. Industry or business

FATHER
12. Name James F Farmer
13. Birthplace Ireland

MOTHER
14. Maiden Name Eupha T. Maxwell
15. Birthplace Balto Md

16 (a) Informant Mrs Chas Farmer
(b) Address 1044 W Overlea ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 30. 45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Balto Md

18 (a) Funeral director Walter Schilling
(b) Address 3914 E. Hanover St.

19 (a) 1945 (Entry rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 26 1945 at 2:57 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11 5 1945 to 11 26 1945, and that I last saw h[illegible] alive on 11 25 1945.

Immediate cause of death Respiratory Failure — Duration
Due to Hypostatic Pneumonia
Due to
Other Conditions Fracture of Femur. Decubiti
(Include pregnancy within 3 months of death)
Date of operation 11-28-44.
Major findings of operation: Open Reduction (Fract. of femur).
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide Acc.
(b) Date of occurrence Dec. 27, 1944 at M
(c) Where did injury occur? Car Home
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fell down stairs

23. Signature Nathan S. Edwards M. D.
Address St Joseph's Hosp. Date signed 1/25/45

VS 150

For Dr. C. J. Lubowski, by Thomas L. Malevitz, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25209 — BALTIMORE CITY HEALTH DEPARTMENT — G25209 Registered No.

CERTIFICATE OF DEATH V 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere
(c) Hospital or institution: Hebrew Home for Aged & Infirm
(d) Length of stay in hospital or inst. (~~yrs.~~, mos., ~~or days~~) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SIGMUND HARRIS

3 (b) If veteran, name war —
3 (c) Social Security Account No. 720-07-0

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Separated

6 (b) Name of husband or wife Bessie Harris
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) March 6-1875

8. AGE: Years 69 | Months 10 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business Book Keeper

FATHER
12. Name Louis Harris
13. Birthplace Germany

MOTHER
14. Maiden Name Dora [illegible] May
15. Birthplace Germany

16 (a) Informant Louis Harris
(b) Address 3714 Avon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29 45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto County Md

18 (a) Funeral director J. Abrams Co
(b) Address 832 Eutaw St

19 (a) [illegible] registrar Huntington Williams, M.D.

JAN 28 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1945 at 1 90 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1944, to Jan 27, 1945, and that I last saw h[illegible] alive on Jan 27 1945

Immediate cause of death	Duration
Nephritis chronica	
Due to	
Due to	
Other Conditions Hypertensive cardio-vascular disease. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury

23. Signature Henry Vogel for Dr. Albert Goldstein M. D.
Address Hebrew Home for Aged Date signed Jan 27, 45

X

G25210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G25210

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Light Street

(c) Hospital or institution South Baltimore Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 3/4 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) "

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Baltimore

(If outside city or town limits write RURAL and give town)

(d) Street No. 1055 Bristol Pl.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Mullis

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 27, 1945

8. AGE: Years	Months	Days	If less than one day
			3 hr. 45 min.

9. Birthplace South Baltimore Gen. Hosp.

(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER

12. Name William Robert Mullis

13. Birthplace ?

MOTHER

14. Maiden Name Christina G. Mullis

15. Birthplace Virginia

16 (a) Informant W. Mullis

(b) Address 1055 Bristol Pl.

17 (a) Removal (b) Date thereof Jan. 28, 1945

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Lynchburg Va.

18 (a) Funeral director Flynn & Flemming

(b) Address 1426 Light St

19 (a) JAN 28 1945 (b) Huntington Williams M.D.

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1945, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12:30 P.M. 1/27 1945, to 4:15 P.M. 1/27 1945 and that I last saw h[illegible] alive on 1/27 1945.

Immediate cause of death	Duration
A. Atelectasis	
Due to Prematurity (7 months old)	
Due to Wt. 5 - 3' 4 1/4"	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature John Madison Blythe III M. D.

Address South Bal. Gen. Hosp. Date signed 1/27/1945

Hosp X

G65211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G65211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 Eggers Lane (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) **FULL NAME** David E. Minnick

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1943

8. AGE: Years 1 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name John David Minnick
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Mary Agnes Krueger
15. Birthplace Balto. Md.

16 (a) Informant The Father
(b) Address 15 Eggers Lane, Catonsville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29, 1945 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Rockland Howard Co. Md.

18 (a) Funeral director Easton Sons.
(b) Address 608 Frederick Ave Catonsville, Md.

19 (a) Huntington Williams, M.D. (Date received by Registrar)

JAN 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26 1945, at 9:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/26 1945, to 1/26 1945, and that I last saw him alive on 1/26 1945.

	Duration
Immediate cause of death Cardiac Failure	
Due to Scarlet Fever	8 Days
Due to	
Other Conditions Anemia Edema	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at P.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Clayton W. Jones Jr. M.D.
Address Eglin Farm Date signed

625212
467846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. 625212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 Conduit St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Patteram

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-14-45

8. AGE: Years	Months	Days	If less than one day
		14	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew Patteram
13. Birthplace Fla.

MOTHER
14. Maiden Name Ora Ellen Breech.
15. Birthplace Wis.

16 (a) Informant Rhonda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Bluff
Location Annapolis Md.

18 (a) Funeral director B. L. Hopkins
(b) Address Annapolis, Md.

19 (a) JAN 29 1945 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan-27- 1945, at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-24 1945, to Jan-27 1945, and that I last saw h[illegible] alive on Jan 27- 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Pediopathic	
Due to Hypertrophy of Heart	
Other Conditions Cleft Palate Hemorrhage	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Kaye M.D.
Address [illegible] Date signed Jan 29 1945

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G25213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G25213

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 162 Dolphin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No.

3 (a) FULL NAME John Royster

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	married

6 (b) Name of husband or wife Alice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1900

8. AGE: Years	Months	Days	If less than one day
44	5	15	hr. 14 min.

9. Birthplace Clarksville Virginia (Town, county, and state)
10. Usual Occupation Jobbing
11. Industry or business

FATHER
12. Name Ruffin Royster
13. Birthplace North Carolina

MOTHER
14. Maiden Name Sarah Jones
15. Birthplace North Carolina

16 (a) Informant Sarah Royster
(b) Address 162 Dolphin Street

17 (a) (Burial, cremation, or removal) (b) Date thereof Jan 29 45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 JAN 29 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 1945, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1945, to 1/26 1945, and that I last saw him alive on 1/26 1945.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension + Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Cooney
Address Provident Hospital Date signed 1/26/45 (M. D.)

X

G25214
467738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47C

G25214 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Dusko

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-24-90

8. AGE: Years	Months	Days	If less than one day
54	4	2	hr. min.

9. Birthplace Poland.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel Dusko
13. Birthplace Poland.

MOTHER
14. Maiden Name Mary Kuc.
15. Birthplace Poland

16 (a) Informant Parents.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Jan. 30 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1730 Eastern Ave.

19 (a) (Local registrar) (b) Huntington Williams M.D.
JAN 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 26 - 1945 at 1145 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-23 1945 to Jan-26 1945 and that I last saw him alive on Jan-26 - 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Bronchogenic carcinoma 5 mos	
Due to Contusion of chest wall mediastinum & lungs	
Other Conditions none	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Abraham Benezra M. D.
Address Johns Hopkins Hospital Date signed 1-27-45

X

625215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. 625215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 925 Leadenhall St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs.) mos., or days) 25

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 925 Leadenhall St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Frances West

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of ~~husband~~ or wife Edward West

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1878

8. AGE: Years	Months	Days	If less than one day
66	2	—	hr. min.

9. Birthplace Calvert Co., Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER

12. Name Henry Smith

13. Birthplace Md

MOTHER

14. Maiden Name Isabelle Parker

15. Birthplace Md

16 (a) Informant Mary E. Johnson

(b) Address 925 Leadenhall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location a. a. Co. Md

18 (a) Funeral director Isaiah L Brown & Son

(b) Address 108 W. Montgomery St

19 JAN 29 1945 (b) Huntington Williams (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26 1945 at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/22 1945, to 1/26 1945, and that I last saw h~~er~~ alive on 1/26 1945

Immediate cause of death	Duration
(a) Pneumonia	
(b) Myocarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature David Crawford M. D.

Address 1122 W. Lee Date signed 1/27/45

VS 150

G25216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47D

G25216 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3114 Harford Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Steven Hayden.

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married.

6 (b) Name of husband or wife Katie Hayden
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) 8/2/66.

8. AGE: Years	Months	Days	If less than one day
78	5	24/25	hr. min.

9. Birthplace St. Mary's County
(Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name HAYDEN
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARY E. BOND
15. Birthplace MARYLAND

16 (a) Informant BENJAMIN S. HAYDEN JR
(b) Address 229 SUDBROOK AVE

17 (a) Burial (b) Date thereof 1/30/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location

18 (a) Funeral director Chas. J. Evans & Son Inc
(b) Address 118 W. Mt. Royal Ave.

19 (a) (Date received by Registrar) JAN 29 1945 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27 1945, at 2:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/21 1945 to 1/27 1945 and that I last saw him alive on 1/26 1945.

Immediate cause of death: Respiratory Failure — Duration:

Due to: Hypostatic Pneumonia

Due to: CA. in Lung

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank L. Vanni, M. D.
Address St. Jos. Hosp. Date signed 1-28-45

G25217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1860

G25217 Registered No.

Today

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: So. Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State M (b) County U.S.A.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1640 N Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELLEN COUZENS.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: F. | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife WILLIAM S. COUZENS
6 (c) If alive, give age 90 years

7. Birth date of deceased (mo., day, yr.) 2-25-1859

8. AGE: Years	Months	Days	If less than one day
85	11	1	hr. min.

9. Birthplace BALTO. Md. (Town, county, and state)
10. Usual Occupation H. Wife.
11. Industry or business

FATHER
12. Name William Muir
13. Birthplace BALTO. MD

MOTHER
14. Maiden Name ANN.
15. Birthplace

16 (a) Informant MRS. JAMES HUBBARD
(b) Address 1640 N. BOND ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 29 - 1945 (month) (day) (year)
(c) Cemetery or crematory MORELAND MEMORIAL
Location

18 (a) Funeral director Chas. J. Evans & Son Inc
(b) Address 118 W. Mt. Royal Ave

19 (a) JAN 29 1945 (Date rec'd by Registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26- 1946 at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1944 to 1-26 1946 and that I last saw her alive on 1-26-1945.

Immediate cause of death Hypostatic Pneumonia — Duration
Due to
Due to
Other Conditions Arteriosclerosis Fracture neck left femur
(Include pregnancy within 3 months of death)
Date of operation 12-25-44
Major findings of operation: Fracture neck left femur
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 8/6
(a) Accident, suicide, or homicide
(b) Date of occurrence 12-17-44 at 1 P.M
(c) Where did injury occur? City. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME While at work or at home (Specify type of place)
(e) Means of injury Fracture left femur

23. Signature Paul L. Jarkate M. D.
Address 1213 Light St. Date signed 1-26-45

S.C.J. Subrosski, by Howard J. Wiedeis, M.D. X

625218 ✓ 625218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 A

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 856 Harford Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius F. Birkmaier

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife: Anna Louise Birkmaier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-24, 1897

8. AGE: Years 47 | Months 1 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired Employee
11. Industry or business Balto Ironrail Co.

FATHER
12. Name Joseph F Birkmaier
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mary Moylan
15. Birthplace Balto Md

16 (a) Informant Mrs. Anna Louise Birkmaier
(b) Address 856 Hartford Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Ave.

18 (a) Funeral director Alberts L Hilt Jr
(b) Address 606 N Chester St

19 (a) [illegible] Registrar
(Date received by Registrar) Huntington Hollander, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26 1945, at 3 a0 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19 1944 to 1-26 1945.
and that I last saw him alive on 1-26 1945

Immediate cause of death	Duration
Cardiac Failure	
Due to Old Coronary occlusion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M.E. Robertson M. D.
Address St Josephs Hosp Date signed 1-26-45

X

625219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 625219

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 Ellerslie Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME EDWARD STARR POSEY

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 213-01-4332

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hilda Matilda Posey

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov, 18, 1874

8. AGE: Years	Months	Days	If less than one day
70	2	7	..... hr. ..... min.

9. Birthplace St. Marys Co., Md.
(Town, county, and state)

10. Usual Occupation Out side Machinist

11. Industry or business Amer. radiator Co.

FATHER
12. Name John Shaw Posey
13. Birthplace St. Marys Co. Md

MOTHER
14. Maiden Name Ellen Newton
15. Birthplace St. Marys Co. Md.

16 (a) Informant Mrs. Hilda M. Posey
(b) Address 3520 Ellerslie Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park cemetery
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) JAN 29 1945 (Date rec'd by local registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1945, at 5:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to .....

Other Conditions Multiple Fractures of Ribs, right

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury Jan. 25th 1945 26/6 45 2 P.M.
(b) Where did injury occur? 5313 Holabird Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell From Ladder

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 1-26-45

VS 151

625220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 F

Registered No. G25220

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Colv. & Saratoga
(c) Hospital or institution: Mercy Hosp. H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 635 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Anthony Cataldi CATALDI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: S.

6 (b) Name of husband or wife

If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/12/43

8. AGE: Years 1 | Months 3 15 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation child.

11. Industry or business —

FATHER
12. Name Samuel Cataldi
13. Birthplace New Jersey.

MOTHER
14. Maiden Name Eleonor Ash.
15. Birthplace Balt. Md.

16 (a) Informant Mother
(b) Address 635 W. Saratoga St. Balto Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/45 (mo.) (day) (year)
(c) Cemetery or crematory Mt. S. National
Location Balto Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

JAN 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27-45 1945, at 2.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20 1945 to 1-27-1945, and that I last saw him alive on 1-27-1945.

Immediate cause of death Pneumococcic meningitis — Duration

Due to Lobar pneumonia and pneumococcus septicaemia

Due to

Other Conditions Cavgenous Sinus.

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation: None.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M. D.
Address Mercy Hosp Date signed 1-27-45

108

3221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G-30221

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Eager St
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 William St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Forrest

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Lovie Forrest
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Sept 19, 1888

8. AGE: Years	Months	Days	If less than one day
56	4	8	hr. min.

9. Birthplace Penn. (Town, county, and state)
10. Usual Occupation Cook & Butcher
11. Industry or business Merchants Club

FATHER
12. Name William Forrest
13. Birthplace Penn. Malsta Low

MOTHER
14. Maiden Name Madalena Forrest
15. Birthplace Kentucky

16 (a) Informant Fam. chart
(b) Address S.B.G. Hosp

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1210 Park Ave

19 JAN 29 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1945, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on Jan 27 19 45.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Thrombosis, Coronary	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John Madison Blythe III M. D.
Address 1213 Eager St Date signed Jan 27 1945

222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

625222 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden.
(c) Hospital or institution: Maryland Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1450 Light St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Cora L. Suman

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W.

6 (b) Name of husband or wife: Louis Suman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8 1869

8. AGE: Years	Months	Days	If less than one day
75	6	19	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name George Gilbert
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Robert W Suman
(b) Address 1450 Light St.

17 (a) Burial (b) Date thereof 1/31/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Frederick Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 JAN 29 1945 Chas. Carrington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1945, at 12:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30 1944, to Jan. 27 1945, and that I last saw her alive on Jan 27 1945.

Immediate cause of death Bronchopneumonia

Duration

Due to

Due to

Other Conditions Intertrochanteric fractured rt. femur
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence December 7, 1944 M
(c) Where did injury occur? 1450 Light St.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME. While at work? No.
(Specify type of place)
(e) Means of injury FELL FROM a CHAIR. 6

23. Signature E J Brady M. D.
Address Md. Gen. Hosp. Date signed 1-27-45

VS 150 For S.P.J. Zubrucki, by Howard A Manning M.D. X

223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6223

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3604 Hosfrid Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3604 Harford Rd
(If rural give location)
(e) Citizen of foreign country? U (Yes or No)
If yes, name country

3 (a) FULL NAME Maria Kerchoff

3 (b) If veteran, name war: NC
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Edward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1860

8. AGE: Years 84 | Months 4 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Frederick Evans
13. Birthplace Prussia Poland

MOTHER
14. Maiden Name Harriet Thompson
15. Birthplace Prussia, Poland

16 (a) Informant Harriet Kerchoff
(b) Address 3604 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Gold & Md

18 (a) Funeral director Wilhelm & Son
(b) Address 1217 E. Lanvale St

JAN 29 1945 (Date rec'd by registrar)
(Huntington for Williams, M.D.) Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1945, at 2 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1944, to Jan 27 1945 and that I last saw h[illegible] alive on Jan 26 1945

Immediate cause of death: Chronic myocarditis — Duration: 5 years
Due to
Due to
Other Conditions: Fractured femur 12-5-44
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9/2
(a) Accident, suicide, or homicide
(b) Date of occurrence Dec 15 44 at 9 A.M.
(c) Where did injury occur? Home (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury: Fell to floor
23. Signature [illegible] M. D.
Address 6706 Harford Rd Date signed 1-27-45

VS 150

For Dr. J. R. Davis, by Howard S. Thaeler, M.D. X

625224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 625224

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3617 Roland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3617 Roland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Letha E Crouse

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	w	Married

6 (b) Name of husband or wife Charles F. Crouse
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1872

8. AGE: Years	Months	Days	If less than one day
72	2	29	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Calvin L. Amy
13. Birthplace Pa.

MOTHER
14. Maiden Name Margaret Hamburg
15. Birthplace Pennsylvania

16 (a) Informant Charles F. Crouse
(b) Address 3617 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-45 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director William Cook Inc.
(b) Address 131 E. Saint Paul St.

19 JAN 29 1945 Huntington Williams M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25 1945 at 10:40 AM

21. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Sabundi M.D.
Medical Examiner.
Date signed 1/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

625225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

625225 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 34 E Chas St
(c) Hospital or institution: Cambridge Arms Apts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Battotsty
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Cambridge Apts (If rural give location)
(e) Citizen of foreign country? —no— (Yes or No)
If yes, name country

3 (a) FULL NAME Leslie Tilden Bidwell

3 (b) If veteran, name war: no.
3 (c) Social Security Account No. 218-09-0042A

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: O. Bird Bidwell
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 9 1872

8. AGE: Years 72 | Months 5 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace San Francisco - Calif. (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Joseph Tilden
13. Birthplace Mass.

MOTHER
14. Maiden Name Julia Fogrid
15. Birthplace Ohio

16 (a) Informant Mrs Elz. B. Chandler (daughter)
(b) Address Hartford - Conn.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1-30-45 (month) (day) (year)
(c) Cemetery or crematory Gmt Mount
Location Baltimore

18 (a) Funeral director Stewart Memorials
(b) Address 108 W North Ave.

19 (a) JAN 29 1945 (Date received) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1945, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1944 to Jan 28 1945, and that I last saw her alive on Jan 26 1945.

Immediate cause of death	Duration
Bronco pneumonia	3 days
Due to	
Due to	
Other Conditions Cerebral arteriosclerosis	2 years

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Frances W. Gluck M. D.
Address 715 Park Ave Date signed 1/29/45

X

625226

AB-91604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. 625226

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 623 S. Lehigh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Hynson

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Henry W.Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25-1915

8. AGE: Years	Months	Days	If less than one day
29	6	1	hr. min.

9. Birthplace Md. BALTO.MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name Charles Norberg
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia Maxson-or-Merxton
15. Birthplace Md.

16 (a) Informant Beltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 30/45 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART CEM.
Location GERMAN HILL ROAD

18 (a) Funeral director Lilley & Sons
(b) Address 403 S. WOLFE ST.

JAN 29 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26- 19 45 at 7.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15- 1945, to 1-26- 1945, and that I last saw her alive on 1-26- 1945.

Immediate cause of death	Duration
Pulmonary tuberculosis bilateral	2 yrs
Due to	
Due to	
Other Conditions Tuberculous myocanditis & pericanditis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Hillon M. D.
Address Balto. City Hosp. Date signed 1-27-45

VS 150

625227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

625227

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BALTIMORE, MD.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 Kalvanagh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Octavia Kay

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 52 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name NELSON KAY
13. Birthplace ESSEX Co., VIRGINIA

MOTHER
14. Maiden Name SUSIE BUSH
15. Birthplace ESSEX Co. Va.

16 (a) Informant CARRIE VESSA
(b) Address 1815 KALVANAUGH ST.

17 (a) Burial (b) Date thereof 1/30/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location A. F. Co. mdl.

18 (a) Funeral director Chas. H. Alexander
(b) Address 927 N. Mount St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151 JAN 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26-1945, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Edema
Acute Congestion + edema of Brain
Due to
Other Condition Intra trochanteric fracture.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 1-22- at 15/3 9 A.M.
(b) Where did injury occur 1800 Block - Warwick Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Slipped on icy pavement

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 1-27-45

625228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 625228

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 S. Port Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John Siemann

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-7-77

8. AGE: Years	Months	Days	If less than one day
67	10	20	.....hr. .....min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Lumber inspector
11. Industry or business

FATHER
12. Name Peter Siemann
13. Birthplace England

MOTHER
14. Maiden Name Elizabeth Winters
15. Birthplace Germany

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Jan 31
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location City

18 (a) Funeral director Ellicott Funeral Home
(b) Address 2004 E. Oliver St

19 (a) JAN 31 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1945 at 6:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24 1945 to Jan. 27 1945 and that I last saw him alive on Jan. 27 1945.

Immediate cause of death Respiratory failure — Duration 30 seconds

Due to ? cerebral vascular accident
? cerebral embolus

Due to Hypertensive arteriosclerotic cardiovascular disease & cardiac failure — ? Syps

Other Conditions failure

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Abraham Siemain M. D.
Address Johns Hopkin Hosp Date signed 1-27-45

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G25229

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 7 Franklin Square Hosp.

(c) Hospital or institution: 7 Fayette & Carlton

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1000 E Pratt (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Matilda Klein

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 3-1876

8. AGE:	Years	Months	Days	If less than one day
	68	1	24	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation

11. Industry or business Confectionery

FATHER

12. Name John Klein

13. Birthplace Germany

MOTHER

14. Maiden Name Emma Martini

15. Birthplace Germany

16 (a) Informant Mrs A Klein

(b) Address 1521 Mt Royal

17 (a) Burial (b) Date thereof Jan 30 (month) (day) (year)
(Burial, cremation, or removal)

(c) Cemetery or crematory Mt Carmel City

Location

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2004 E Orleans St

19 (a) 1-29-45 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27 1945, at 2 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16 1945 to 1-27 1945, and that I last saw h[illegible] alive on 1-27 1945.

Immediate cause of death	Duration
Cachexia	
Due to Undiagnosed abdominal tumor & Concurrent	
Due to Cerebro-vascular accident (Arteriosclerotic)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature J. Carl Myers M. D.

Address Franklin Sq. Hosp. Date signed 1/27/45

625230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 625230

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 N Eris Ave
(c) Hospital or institution:
Mercy Hospital Balto. Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 917 N. Eris Ave. Balto. Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Bates ~~Lightcap~~

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-24-3858

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Andrew Bates
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? Oct 9 - 1882

8. AGE: Years	Months	Days	If less than one day
62?	3	19 / 12	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housekeeper Saleslady
11. Industry or business Saleslady

FATHER
12. Name Charles Bragg
13. Birthplace Md

MOTHER
14. Maiden Name Annie E Victory
15. Birthplace Md

16 (a) Informant Mrs. Andrew Bates Jr.
(b) Address 917 N. Eris Ave.

17 (a) Burial (b) Date thereof Jan. 31.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2104 E Orleans St

19 (a) 1/29/45 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28th 1945, at 4 40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 25th 1945, to Jan. 28 1945, and that I last saw her alive on Jan. 28th 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Hypertension C.V.D.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. De. P. Tinker, M.D.
Address Mercy Hospital Date signed 1/28/45

VS 150

G25231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G25231 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hillsdale Rd
(c) Hospital or institution:
Florences Nursing Home
Shriners
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 E. Belvedere av
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arlington Speaden

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Carrie M. Speaden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1- 1873

8. AGE: Years 71 | Months 5 | Days 26 | If less than one day hr. min.

9. Birthplace Dorchester Co. Md.
(Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business Seeds

FATHER 12. Name Hezekiah Speaden

13. Birthplace Dorchester Co Md

MOTHER 14. Maiden Name Laura Hubbard

15. Birthplace Dorchester Co. Md.

16 (a) Informant Emerson D. Speaden (son)

(b) Address 911 E. Belvedere Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 30, 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto. Md.

18 (a) Funeral director Robert S. Little

(b) Address 2700 Edmondson Ave.

19 (a) JAN 29 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1945, at 9 45a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1945 to June 26 1945, and that I last saw h.er alive on June 26 1945.

	Duration
Immediate cause of death: Broncho Pneumonia	2 d.
Due to Arteriosclerosis	7 y.
Due to Chr. Interstitial Nephritis	7 y.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. F. A. Stevens M. D.

Address 2818 Harford Rd Date signed 1-27-45

625232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 625232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2304 Calverton Heights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 53 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 Calverton Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion L. Barfoot,

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Caroline Barfoot,
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) April 14 1867

8. AGE: Years	Months	Days	If less than one day
77	9	14	..... hr. ..... min.

9. Birthplace Richmond Va. (Town, county, and state)
10. Usual Occupation Stationery Enginer
11. Industry or business City School

FATHER
12. Name Arbert Barfoot
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Caroline Barfoot.
(b) Address 2304 Calverton Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 31. 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co.

18 (a) Funeral director George W. Little,
(b) Address 2700 Edmondson Ave.

19 (a) ..... (Registered by registrar) (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 28 1945 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1945 to Jan 28 1945 and that I last saw him alive on Jan 28 1945.

Immediate cause of death	Duration
Myocardial infarction, arteriosclerotic type heart disease	
Due to Bronchopneumonia	6 days
Due to	
Other Conditions Generalized arteriosclerosis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Michael M. D.
Address 2700 Edmondson Ave Date signed Jan 28 45

JAN 29 1945 Huntington Williams, M.D.

VS 150

X

625233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 81 A

Registered No. 625233

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. of A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 916 N. Arlington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Valdina (Madeleine) Rice

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/24/44

8. AGE: Years	Months	Days	If less than one day
1	-	3	hr. min.

9. Birthplace Balto. Md (town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Nathaniel Rice
13. Birthplace Md

MOTHER
14. Maiden Name Helen Chase
15. Birthplace Md

16 (a) Informant Helen Rice
(b) Address 916 N. Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 313 Park Avenue

19 (a) JAN 29 1945 (Date rec'd by registrar) (b) Hunter for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1945, at 6 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Purulent Meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Grafton M.D.
Medical Examiner.
Date signed Jan 28 1945

625234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 A

Registered No. 625234

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1628 W. Lanvale
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 1
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 W. Lanvale (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James P. Kurtz

3 (b) If veteran, name war: ✓ | 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Sylvia Kurtz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8 1904

8. AGE: Years	Months	Days	If less than one day: hr.	min.
40	8	21		

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Arthur Kurtz
13. Birthplace Md

MOTHER 14. Maiden Name Mary —
15. Birthplace Md

16 (a) Informant Sylvia Kurtz
(b) Address 1628 W. Lanvale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/45 (month) (day) (year)
(c) Cemetery or crematory Gulutus
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pleasant St

19 (a) JAN 29 1945 (Date received by Registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30/45 19 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/23/45 to 1/27/45, and that I last saw h[illegible] alive on 1/26/45

Immediate cause of death: Coronary occl. due to

Due to

Due to

Other Conditions: Hardening Arteries
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 1/30/45

(OVER)

5235

AB-91491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. 625235

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 20 S. High St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Joseph Reddy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-4-1899 1889

8. AGE: Years 55 55 | Months 4 | Days 11 | If less than one day hr. min.

9. Birthplace N.Y.
(Town, county, and state)

10. Usual Occupation Brick Layer

11. Industry or business

FATHER
12. Name Talmadge (D)
13. Birthplace Ireland

MOTHER
14. Maiden Name Nora Kelly (D)
15. Birthplace England

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29th 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo J. Meade
(b) Address 1701-03 N. Patterson Park Ave

19 (a) JAN 29 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15- 1945 at 10P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-8- 1945 to 1-15- 1945 and that I last saw h im alive on 1-15 1945

Immediate cause of death: Carcinoma of Rectum, primary site undetermined — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Kenneth Smith

Address Balt. City Hosp. Date signed 1/28/45

VS 150

5236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 625236

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 1 Stap Smith Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town St. George's Reisterstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Calvin Gore

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-6214

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Daisy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/9/1880

8. AGE: Years 64 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Reisterstown Baltimore Co.
(Town, county, and state)

10. Usual Occupation Carpenter.

11. Industry or business

FATHER 12. Name Jay Gore
13. Birthplace Reisterstown Md.

MOTHER 14. Maiden Name Ella Hafferty
15. Birthplace Reisterstown, Md.

16 (a) Informant Daisy Gore
(b) Address St. George's

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 31 '45 (month) (day) (year)
(c) Cemetery or crematory All Saints
Location Reisterstown, Md.

18 (a) Funeral director Wm Berry mgr
(b) Address Reisterstown, Md.

19 (a) JAN 29 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1945, at 2:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Sub-arachnoid Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 12/5

(a) Date of injury 1-23- at 2.30 P M.
(b) Where did injury occur? 15 S. 21st St
(c) Did injury occur at home, on farm, industrial place, in public place? ? While at work? Yes
(d) Means of injury Fell 4' on head

23. Signature Howard J. Weldeis M.D.
Medical Examiner.
Date signed 1-28-45

VS 151

625237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940 625237

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1515 Millington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 Millington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlie Cooper

3 (b) If veteran, name war —

3 (c) Social Security Account No. 705-10-9438

4. Sex: M

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Evelyn Cooper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889 Dec.

8. AGE: Years 55 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Glouster Co Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Anthony Cooper
13. Birthplace Gloucester Co, Va

MOTHER
14. Maiden Name Lula Driver
15. Birthplace Gloucester Co Va

16 (a) Informant Evelyn Cooper
(b) Address 1515 Millington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 30-45 (month) (day) (year)
(c) Cemetery or crematory Antietam Memorial
Location Antietam Maryland

18 (a) Funeral director Robert F. Williams
(b) Address 1515 McElderry St

19 (a) JAN 29 1945 (Date received by registrar) Huntington Hollins, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 1945 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1945 to 1/25 1945
and that I last saw h alive on 19

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Burk Roberts M. D.
Address 1515 Millington St Date signed 1/29/45

1 6 8 5 2 3 8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 472

Registered No. 6 6 5 2 3 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga
(c) Hospital or institution: Mercy Hosp V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos 24 D
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 823 S. Paca St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ANTONIO (Anthony) Sorrentino

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-05-1239

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mary SORRENTINO
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6-1891

8. AGE: Years 53 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Italy (City, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Pasquale Sorrentina
13. Birthplace Italy

MOTHER
14. Maiden Name Mary F. Garlance
15. Birthplace Italy

16 (a) Informant MARY SORRENTINO
(b) Address 823 S PACA ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 31-45 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location BALTO MD

18 (a) Funeral director Bernard C Hurle
(b) Address 121 E WEST ST

19 (a) (Signature of local registrar) (b) Huntington Williams M.D. Registrar

JAN 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1945 at 6 17 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1944, to Jan 27 1945, and that I last saw him alive on Jan 27 1945

Immediate cause of death	Duration
Cachexia	
Due to Bronchogenic carcinoma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchogenic Carcinoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Luther
Address Mercy Hosp Date signed 1/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2 GB3239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 10 GB3239

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd
(c) Hospital or institution: Sydenham Hosp. 23
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 Light St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joanne A Wells

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-18-43

8. AGE: Years	Months	Days.	If less than one day
1	11	10	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name LLOYD [illegible] Wells
13. Birthplace Baltimore

MOTHER
14. Maiden Name Rita Mitendiner MEIXNER
15. Birthplace Baltimore

16 (a) Informant Father
(b) Address 1606 Light St

17 (a) Burial (b) Date thereof Jan 31 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Balto Md
Location
18 (a) Funeral director Bernard C Hart
(b) Address 121 E West St

19 (a) JAN 29 1945 (b) Registrar
(Date received by local registrar)
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21 1945, to 1-28 1945, and that I last saw h[illegible] alive on 1-27 1945.

Immediate cause of death	Duration
Heart Failure	
Due to Asphyxia & Myocarditis	12 hrs. and 1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clifton W Govan Jr M. D.
Address Sydenham Date signed

X 1-28-45

2 copies
G25240

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

830 Registered No. G25240

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1612 JACKSON ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 JACKSON ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CLARA. E LANGE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEM | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife JOHN A LANGE

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) AUG 12 1883

8. AGE: Years 61 | Months 5 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business —

FATHER
12. Name PHILLIP FRICK
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ELIZABETH BARNES
15. Birthplace MARYLAND

16 (a) Informant JOHN A LANGE
(b) Address 1612 JACKSON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 30-45 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location A.A.C.

18 (a) Funeral director Bernard C Hanke
(b) Address 121 E West St

19 (a) JAN 29 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 27 1945, at 11 50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 1944, to 1-27 1945, and that I last saw h[illegible] alive on 1-27 1945

	Duration
Immediate cause of death: Cerebral Hemorrhage	1-26-45
Due to: Arteriosclerosis	14 yrs.
Due to:	
Other Conditions:	
(Include pregnancy within 3 months of death)	

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Hallock M. D.
Address 707 E. Fortune Date signed 1-27-45

Huntington Ave

G25241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G25241

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1203 Light Street
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 Bond Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES E LEWIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Martha A Alexander. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/13/1864

8. AGE: Years	Months	Days	If less than one day
80	3	18	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Case Maker
11. Industry or business
FATHER 12. Name Henry Lewis
13. Birthplace Md.
MOTHER 14. Maiden Name Unknown
15. Birthplace Md
16 (a) Informant Mr. H. Lewis
(b) Address 1302 Stanrapt St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location
18 (a) Funeral director J. J. Doherty & Son
(b) Address 1318 Light St. Huntington Williams, Md
19 (a) JAN 29 1945 (b) Registrar
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1945, 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Ward M.D.
Medical Examiner.
Date signed January 28, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G25242 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 N. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Hughes or Addie Hughes

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 61 60 | Months | Days | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Lena L. Keene
(b) Address 612 N. Stockton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley and

19 JAN 29 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-25-45 at 3:50 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 1-25-45

VS 151

G25243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G25243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address. Redwood & Greene sts.
(c) Hospital or institution:
Univ. Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110-8 West. 13th.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Leo Rush.

3 (b) If veteran, name war: No
3 (c) Social Security Account No. No

4. Sex: M. | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 4 - 1882

8. AGE: Years 62 | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace Balto md Ms.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charles Francis Rush
13. Birthplace Balto Md

MOTHER
14. Maiden Name Kunegunda Hahn
15. Birthplace Balto Md

16 (a) Informant Mrs. Frank T. Parr
(b) Address 7 Ridge Rd Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Ave

18 (a) Funeral director Henry Sanders & Sons Inc
(b) Address Nath. Ave & Broadway

JAN 29 1945 (Date received by Registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26 1945 at 11:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1945 to 1-26 1945 and that I last saw him alive on 1-26 1945

Immediate cause of death: Cardiac failure — Duration

Due to Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address Univ. Hosp. Date signed 1-26-45

5244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46M

Registered No. G25244

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: University Hospital 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County.....

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1804 Bolton St

(If rural give location)

(e) Citizen of foreign country? ~ (Yes or No)

If yes, name country ~

3 (a) **FULL NAME** ADELAIDE E. JENKINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Thomas X. Jenkins

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) ~ 1863

8. AGE: Years	Months	Days	If less than one day
82	~	~	~ hr. ~ min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER

12. Name Stephen Musgrove

13. Birthplace Md.

MOTHER

14. Maiden Name Julianna White

15. Birthplace Md.

16 (a) Informant Adelaide H. Jenkins

(b) Address 1804 Bolton St.

17 (a) Burial (b) Date thereof 1/31/45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director H. W. Myers and Son

(b) Address 505 N. Calvert St.

19 (a) (b)

(Date received by Registrar) Registrar

JAN 29 1945

Huntington W. Howard, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28 1945, at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1945, to 1-28 1945, and that I last saw h[illegible] alive on 1-27 1945.

Immediate cause of death	Duration
Obstruction	
Due to Carcinoma	over
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:.....

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at ..... M

(c) Where did injury occur?.....

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....

(Specify type of place)

(e) Means of injury.....

23. Signature Wm. Carl Ebeling III M. D.

Address Univ. Hosp. Date signed 1-28-45

G25245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G25245

Registered No. 5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 N. Port Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523 N. Port Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jirecek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or ~~wife~~ Aloia (deceased)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1874

8. AGE: Years	Months	Days	If less than one day
70	4	23	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Komarek
13. Birthplace Czech.

MOTHER
14. Maiden Name Unknown
15. Birthplace Czech.

16 (a) Informant Anna Watson (daughter)
(b) Address 3155 Ravenwood Avenue

17 (a) Burial (b) Date thereof 1/31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horner's Lane

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) JAN 29 1945
(Signature, address, and title) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27-45 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27-44 19 to 1-27-45 19, and that I last saw h[illegible] alive on 1-26-45 19

Immediate cause of death	Duration
Pulmonary tuberculosis	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date of death 1-27-45

VS 150

625246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 625246

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3232 Dudley Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3232 Dudley Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Neuman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or xxx Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1864

8. AGE: Years	Months	Days	If less than one day
80 yrs.	11	24	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Martinek
13. Birthplace Czech.

MOTHER
14. Maiden Name Unknown
15. Birthplace Czech.

16 (a) Informant Gabriella Elsnic
(b) Address 3232 Dudley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/45 (month) (day) (year)
(c) Cemetery or crexxxy Oak Hill
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) Filed by [illegible] Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1945, at 6 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1941 to Jan 26 1945 and that I last saw h[illegible] alive on Jan 26 1945

Immediate cause of death	Duration
Hypo. Uremia	1/24/45
Due to Chr. Myocard. Deg.	7/1/41
Due to Arterio. Sclerosis	1939
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Ryan M.D.
Address 801 N. Kenwood Date signed 1/28/45

VS 150

625247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

460

Registered No. 625247

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st
(c) Hospital or institution:
US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo11 da
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mo11 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (Maryland) County
(c) City or town Cincinnati (If outside city or town limits, write RURAL and give town)
(d) Street No. 431 W. 4th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CALDWELL, WILLIAM HAYES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/10/76

8. AGE: Years	Months	Days	If less than one day
68	2	17	hr. min.

9. Birthplace Hillsboro, Ohio (Town, county, and state)

10. Usual Occupation Carpenters Helper

11. Industry or business

FATHER 12. Name Oliver Caldwell

13. Birthplace Ripley, Ohio

MOTHER 14. Maiden Name Frances Young

15. Birthplace West Virginia

16 (a) Informant Records-USMarine Hospital

(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary-

Location Annapolis Rd-

18 (a) Funeral director A Lee Elder-

(b) Address 4674 York Rd-

19 (a) JAN 29 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 1945 at 7:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/14 1944 to 1/27/ 1945, and that I last saw h. im alive on 1/27/ 1945

Immediate cause of death: Carcinoma of the esophagus with perforation into the rt. lung — Duration: Unk.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley D. Lewis M. D.

Address US Marine Hospital Date signed 1/27/45
Baltimore, Maryland.

625248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625248 / 1172 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully s... Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 39 days
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2522 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Royal A. Ford.
3 (b) If veteran, name war None
3 (c) Social Security Account No. 213-16-4037
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Helen M. Ford
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) August 24-1880
8. AGE: Years 64 Months 5 Days 1 If less than one day hr. min.
9. Birthplace Md (Town, county and state)
10. Usual Occupation Carpenter
11. Industry or business
FATHER 12. Name George Ford
13. Birthplace Md
MOTHER 14. Maiden Name ?
15. Birthplace ?
16 (a) Informant Helen M. Ford
(b) Address 2522 Frederick Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29-1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City
18 (a) Funeral director Roth C. B. M. Walter
(b) Address Pratt & Stricker Sts
JAN 29 1945 (a) (Date received by registrar) (b) Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25 1945 at 12:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.
Immediate cause of death Toxemia — Duration 6 days.
Due to Pulmonary Edema — 5 days
Due to Pneumonia — 39 days
Other Conditions Prof. Septic Sore Throat
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Patrick Dodd M. D.
Address Univ. Hosp. Date signed 1/25/45

X

VS 150

G25249

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G25249
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Be sure to correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8 Pearl Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Pearl St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie C. Bowers

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Late Frank Bowers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 11th 1869

8. AGE: Years 75 | Months 11 | Days 16 | If less than one day hr. min.

9. Birthplace Penna (Town, county, and state)
10. Usual Occupation house work
11. Industry or business at home

FATHER
12. Name John Smith
13. Birthplace Penna

MOTHER
14. Maiden Name Eleanor
15. Birthplace Penna

16 (a) Informant Mrs William F Bowers
(b) Address 8 Pearl Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location 2930 Frederick Ave

18 (a) Funeral director John J Cowan & Son
(b) Address 906-08 Hollins St.

19 (a) (Person acting as funeral director) (b) Huntington Williamsport, Md

JAN 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27th 1945, at 12.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1945 to 1-27 1945, and that I last saw h[illegible] alive on 1-27 1945

Immediate cause of death Bronchopneumonia — Duration 5da
Due to Generalized Arteriosclerosis
Due to Arteriosclerotic Cardiovascular Disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dwight G Landcastle M. D.
Address 679 Washington Blvd Date signed 1/29/45

G25250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1944

G25250 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 511 Rock Glen Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)

(d) Street No. 511 Rock Glen Rd
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sterling S Snader

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband or wife~~ Minnie F

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 30 1876

8. AGE: Years 68 | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace Carroll Co. Md
(Town, county, and state)

10. Usual Occupation Retired Letter Carrier

11. Industry or business

FATHER 12. Name Henry M Snader

13. Birthplace Md

MOTHER 14. Maiden Name Sarah Zepp

15. Birthplace Md

16 (a) Informant Minnie F Snader

(b) Address 511 Rock Glen Rd

17 (a) Burial (b) Date thereof 1 30 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Snader

Location Westminster Md

18 (a) Funeral director Grant H Sauk

(b) Address 814 N 36 St

19 (a) JAN 29 1945 Hiltz for Williams H.D.
(Date rec'd by registrar) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1945 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1944 to Jan 27 1945 and that I last saw him alive on Jan 26 1945

Immediate cause of death	Duration
Coronary Thrombosis.	28 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature A P Von Schulzmund M. D.

Address 4818 Edmondson Date signed Jan 27 1945

G25251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G25251 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto Md
(b) Street address 727 W Lafayette St
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 727 W. Lafayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marvin O. Cralle

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-14-3765

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21-1889

8. AGE: Years 55 | Months 5 | Days 6 | If less than one day ____hr. ____min.

9. Birthplace Northumberland Va (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name John Butts Cralle
13. Birthplace Northumberland

MOTHER
14. Maiden Name Serena Ashburn
15. Birthplace Northumberland Va

16 (a) Informant Mrs Mary George
(b) Address 806 N. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 30-45 (month) (day) (year)

(c) Cemetery or crematory Westview Cemetery Edmondson Ave - Balto

18 (a) Funeral director Martin Bowles Bradley
(b) Address 1920 N Monte ave

19 (a) (Date rec'd by registrar) JAN 29 1945 (b) Huntington Hillman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1945, at 9:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary Edema

Due to Arteriosclerotic Cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Foster M.D. Medical Examiner.
Date signed Jan 28 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

625252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625252 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3326 Burleith Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-5-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3326 Burleith Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD LEO SKANE

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 214-01-8187

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ida E. Skane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1889

8. AGE: Years	Months	Days	If less than one day
55	7	15	....hr. ....min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Masseur
11. Industry or business Danny Frush Health Co.

FATHER
12. Name
13. Birthplace Unk

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 29 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1945, at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1941, to Jan. 26 1945, and that I last saw h[im] alive on Jan. 26 1945.

Immediate cause of death	Duration
Coronary Thrombosis	acute
Due to Arteriosclerosis	
Hypertonitis.	
Due to Emphysema	
Other Conditions Diverticulitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. Keedle M.D.
Address 2314 - Dr. Norris Dr. Date signed 1/29/45

625253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

625253 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3111 Virginia Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3111 Virginia Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GRACE MAY WINTERS

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1878

8. AGE: Years	Months	Days	If less than one day
66	4	17	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name J. William Winters
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Elvira E. Lewis
15. Birthplace Balto., Md.

16 (a) Informant Miss Blanche E. Winters
(b) Address 3111 Viginia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 29 1945 (Date rec'd by registrar) (b) Huntington Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26, 1945, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to Jan 26 1945, and that I last saw h alive on Jan 26 1944

Immediate cause of death	Duration
Carcinoma of Breast	unknown
Due to	
Due to	
Other Conditions Chron. mitral Endocarditis	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature C. B. Enson M. D.
Address 7201 York Rd Date signed 1-29-44

VS 150

G25254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G25254
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2707 Elsinor Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2707 Elsinor Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN PHILIP ALBERT

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lily C. Albert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1868

8. AGE: Years 77 | Months 0 | Days 19 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Accountant - retired

11. Industry or business

FATHER
12. Name Daniel Albert
13. Birthplace Germany

MOTHER
14. Maiden Name Susan Zimmer
15. Birthplace Germany

16 (a) Informant Mrs. Lily C. Albert
(b) Address 2707 Elsinor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 30 '45 (Date rec'd by registrar) (b) Hunting Town Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1943, to 1-27-1945, and that I last saw h[illegible] alive on 1-26-1945

Immediate cause of death: Acute Congestive heart failure — Duration: 2 hours

Due to

Due to Arteriosclerosis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard L. Warner M. D.
Address 2054 Garrison Blvd Date signed 1-29-45

VS 180

G25255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

X G25255 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga. (b) County
(c) City or town Atlanta (If outside city or town limits, write RURAL and give town)
(d) Street No. 181 B 11th NE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Lewis Houck

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War I	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Annie Louise Houck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-24-89

8. AGE: Years	Months	Days	If less than one day
55	2	4	hr. min.

9. Birthplace Goochland Co., Va (Town, county, and state)
10. Usual Occupation Foreman (Construction)
11. Industry or business City of Atlanta

FATHER
12. Name George W. Houck
13. Birthplace Cumberland Co., Pa.

MOTHER
14. Maiden Name Elizabeth Cressler
15. Birthplace Cumberland Co., Pa.

16 (a) Informant Mrs. Annie L. Houck
(b) Address 2026 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 29 1945

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28-1945 at 10:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22-1945 to 1-28-1945 and that I last saw him alive on 1-28-1945

Immediate cause of death	Duration
Respiratory failure	
Due to Pneumonia.	
Due to Cerebral thrombosis	
Other Conditions Hypertensive cardiovascular disease. Diabetus mellitus.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Allen C. Wooden M. D.
Address W.B.G.H. Date signed 1-28-45

93D

G25256 G25256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1/31 a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3007 Westwood Ave.
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 24 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3007 Westwood Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Genevieve H. Harner

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Fem.
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry C. Harner
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) About 1864

8. AGE: Years 81 | Months — | Days — | If less than one day ____ hr. ____ min.

9. Birthplace Emmitsburg, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Pius Hemler
13. Birthplace Emmitsburg, Md

MOTHER
14. Maiden Name LUCINDA Onendorff
15. Birthplace EMMITSBURG, MD

16 (a) Informant Mr. Edward Harner
(b) Address 3007 Westwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/45 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's Cem.
Location Emmitsburg, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore Md.

JAN 29 1945

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1945, at 3 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1943 to Present 19__, and that I last saw her alive on Jan. 27 1945

	Duration
Immediate cause of death: Coronary Occlusion	Sudden
Due to Arteriosclerosis	Many years
Due to Nephritis	Many years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Schmidt M. D.
Address 2924 Brighton St. Date signed 1-28-45

VS 2

625257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

460

625257 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, 14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 7910 Ardmore Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Wilmer Kutsch

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie W. Kutsch
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 27, 1875

8. AGE: Years 69 | Months 8 | Days 0 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired - Proof Reader
11. Industry or business Sun Paper

FATHER
12. Name Mr. George Kutsch
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Schreiber
15. Birthplace Germany

16. (a) Informant Mrs Louis W. Kutsch
(b) Address 7910 Ardmore Ave

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 1/30/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore

18 (a) Funeral director H. Traphagen Sons
(b) Address North & Pennsylvania Ave

19 (a) JAN 29 1945 (Date rec'd by registrar) (b) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27-1945 at 6:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 13 1945 to Jan. 27 1945 and that I last saw him alive on Jan. 27 1945

Immediate cause of death Cardiac failure.

Duration

Due to Carcinoma of the head of the pancreas

Due to with metastases.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 1-26-45
Major findings of operation: Carcinoma of pancreas with metastases
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred S. Crane M. D.
Address Union Memorial Hospital Date signed 1-27-45

VS 150

Huntington Williams M.D.

625258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

625258 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3818 Penhurst Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3818 Penhurst Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: ANNA MARIE WANTZ

3 (b) If veteran, name war: --

3 (c) Social Security Account No.:

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Earl B. Wantz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1901

8. AGE: Years 43 | Months 3 | Days 5 | If less than one day: hr. min.

9. Birthplace Halethorpe, Balto. Co., Md. (Town, county, and state)

10. Usual Occupation Store Mgr.

11. Industry or business Isaac Moss

FATHER
12. Name Michael Reitz
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Anes
15. Birthplace Balto., Md.

16 (a) Informant Mr. Earl B. Wantz
(b) Address 3818 Penhurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) (b) Registrar

JAN 29 1945

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Jan. 27, 1945, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 13 to Jan 27 1945, and that I last saw h er alive on Jan 26 1945.

Immediate cause of death: General Carcinomatosis — Duration: 1 Year

Due to: Carcinoma of B. Duct (left) — 2½ Years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eliot W. Johnson M.D. M. D.

Address 3432 Sulgrave Ave Date signed

625259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

625259 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2857 W. Harrison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2857 W. Harrison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Fulton (SULTON)

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-9036

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Anna —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (town, county and state)

10. Usual Occupation Dresser

11. Industry or business

FATHER 12. Name Morton —

13. Birthplace Russia

MOTHER 14. Maiden Name Chia Hannah —

15. Birthplace Russia

16 (a) Informant Anna Fulton (Ruetow)

(b) Address 2857 W. Harrison

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-45 (month) (day) (year)

(c) Cemetery or crematory Hebrew Rodelph

Location

18 (a) Funeral director Jack Levine Inc

(b) Address 139 E. Balto St

19 (a) (Date received by registrar) (b) Huntington Williams M.D. (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28-45 19 , at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-44 19 44 to 1-28 19 45
and that I last saw him alive on 1-28 19 45

Immediate cause of death Rheumatic Cardio-Vascular Disease | Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph S. Blum M.D.
Address 206 E. Lexington Date signed 1/29/45

625260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625260 Registered No. 46 F

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2612 E. Baltimore St
(c) Hospital or institution: [illegible]
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2128 Fleet St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joachim Lamb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Esther M nee Paul

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22-1880

8. AGE: Years 64 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER 12. Name Abraham Simon

13. Birthplace [illegible]

MOTHER 14. Maiden Name [illegible] Hutter

15. Birthplace [illegible]

16 (a) Informant Esther M. Lamb

(b) Address 2128 Fleet St

17 (a) Remove (b) Date thereof 1-29-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Charlotte, N.C.

Location

18 (a) Funeral director Jos. Louis Inc

(b) Address 1439 E. Balto. St

19 (a) [illegible] (b) Huntington Williamsville, MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26-45 19 at 4 48 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 44 to Jan 26 19 45 and that I last saw h. 5m alive on Jan 26 19 45

Immediate cause of death

Cerebral Concussion 1 mo.

Due to Primary Carcinoma of Liver 2 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature [illegible]

Address 2002 E Baltimore St Date signed 1/29/45

VS 150

625261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 C

625261 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 704 Cathedral St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 704 Cathedral St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James R. Orndorff (James Ridgely Orndorff)

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 705-05-5638

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Maude McIlhaney Orndorff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 7, 1872

8. AGE: Years 72 66 | Months 11 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired Chief Clerk

11. Industry or business Baltimore & Ohio RR

FATHER
12. Name William W. Orndorff
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary J. Ridgely
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Richard M. Ryan
(b) Address 560 W. University Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 31, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Wilbur Lamborn
(b) Address 4510 Liberty Heights Ave.

19 (a) JAN 29 1945 (Date received by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1945, at 10.50 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions Rheumatic Heart

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D. (Medical Examiner.)
Date signed 1-27-45

G25262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G2[illegible] Registration No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4338 Glenmore Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4338 Glenmore Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza May Gary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Junius Herbert Gary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1867

8. AGE: Years	Months	Days	If less than one day
77	6	16	hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Andrew Mayers
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Eliza Virginia Mull
15. Birthplace Richmond, Va.

16 (a) Informant Mrs. Virginia Arnold
(b) Address 4340 Glenmore Ave.

17 (a) Burial (b) Date thereof Jan. 30, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Wm. Lawrence
(b) Address 4510 Liberty Heights Ave.

19 (a) JAN 29 1945 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27th 1945, at 1 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1944 to Jan 27 1945, and that I last saw him alive on Jan 26 1945.

Immediate cause of death Chronic Myocarditis — Duration 2 yrs
Due to myocardial insufficiency — 2 wks.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Bueno, M. D.
Address 1 W. Preston Date signed 1/27/45

625263
AB-91453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1370

625263
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1032 Hillen St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Edward Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1874

8. AGE: Years	Months	Days	If less than one day
70	2	20	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name John Brown
13. Birthplace Va

MOTHER
14. Maiden Name Lucy Blunt
15. Birthplace Va

16 (a) Informant Balto. City Hosp. Records
(b) Address 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County
18 (a) Funeral director Kayser Sanders
(b) Address 1412 E. Preston Street
19 (a) JAN 29 1945 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26th, 1945 at 7:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5 1945 to 1-26 1945, and that I last saw him alive on 1-26 1945.

	Duration
Immediate cause of death Pneumonia	1 day
Due to B.P.H. - Cystitis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
Pneumonia
of autopsy: B.P.H. Cystitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. J. Perry M.D.
Address B.C.H. Date signed 1-26-45 M. D.

Huntington Williams, M.D.

625264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625264 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3607 Parkside Dr.
(If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME Ellsworth L. Burns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine A. Burns
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) June 25, 1860

8. AGE: Years 80 84 | Months 7 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace: Selins Grove, Pa.
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Jacob Burns
13. Birthplace: Pennsylvania

MOTHER
14. Maiden Name: Katherine Kantz
15. Birthplace: Penna.

16 (a) Informant: Mrs. Katherine A. Burns
(b) Address: 3607 Parkside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/45 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Baltimore

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 5305 Harford Road #14

19 (a) JAN 29 1945 (Date received by Registrar) Registrar: Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28 1945, at 12:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-27 1945 to 1-28 1945. and that I last saw him alive on 1-28 1945

Immediate cause of death: Myocardial Infarction & Mesenteric Infarction — Duration: 4 days

Due to: Arteriosclerotic Cardiovascular Disease

Due to: Grade IV.

Other Conditions: None

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: W. C. Eberling III M. D.
Address: University Hosp Date signed 1-29-45

VS 150

G25265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 C

G25265 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3118 E. Balto St. #24
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa K. Platt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widow

6 (b) Name of husband or wife Frank J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1874

8. AGE: Years	Months	Days	If less than one day
70	5	16	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Emanuel Krug
13. Birthplace Austria

MOTHER
14. Maiden Name Smith
15. Birthplace Austria

16 (a) Informant Md. Gen. Hosp.
(b) Address

17 (a) Burial (b) Date thereof Feb 1-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Red.
Location Belgrade Road

18 (a) Funeral director John E. Lodge
(b) Address 308 E. Baltimore St.

(a) JAN 29 1945 (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1945, at 6:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7 1945, to Jan. 28 1945, and that I last saw h.er alive on Jan 28 1945.

Immediate cause of death	Duration
Bronchopneumonia on 13th day after Gastro-enterostomy for Carcinoma of	
Due to the Duodenum	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Jan. 16, 1945
Major findings of operation: Carcinoma of Duodenum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. McCormack M. D.
Address Md. Gen. Hosp. Date signed 1-29-45

VS 150

G25266

AB-91818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G25266 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Physicians: please write the causes of death clearly and legibly. Especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 139 S. Potomac St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alvin Gene Sandlass

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16- 1944

8. AGE: Years	Months	Days	If less than one day
	6	11	hr. min.

9. Birthplace Baltimore-Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Louis Sandlass

13. Birthplace Maryland

MOTHER

14. Maiden Name Louise Sauers

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals (Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 30/ 45 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Baltimore Co. Road

18 (a) Funeral director John C. Horan

(b) Address 3000 E. Baltimore St

19 (a) (b) Date filed JAN 29 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27- 1945, at 7.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26- 1945 to 1-27- 1945, and that I last saw h... alive on 1-27- 1945.

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Laurence, Collateral

Duration
8 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph L. Smith, M. D.

Address Baltimore City Hosp Date signed 1-27-45

X Weiseth

VS 150

625267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1115c

625267 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 Eagle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Gericke

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/26/42

8. AGE: Years	Months	Days	If less than one day
2	2	1	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER 12. Name Alexander C Gericke
13. Birthplace Md

MOTHER 14. Maiden Name Estella E. Noelk
15. Birthplace Md

16 (a) Informant Estella E. Gericke
(b) Address 2022 Eagle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md

18 (a) Funeral director J. B. Hilgert Sons
(b) Address 300 Eastern Ave

JAN 29 1945 (a) (b) Thurston Hollinsworth, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1945, at 1:50 A M

21. I certify that I took charge of the remains described above, held an inspection + inquiry thereof and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Follicular Tonsilitis and Pharyngitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Bratton M.D.
Medical Examiner.
Date signed 1-27-45

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item correct age is especially important.

No. 25268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G25268

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 17 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County None
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 Williams St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Pennington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) 1/25/45 4:54 P.M.

8. AGE: Years | Months | Days | If less than one day: 17 hr. 6 min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Frank John Pennington

13. Birthplace Harmon, W. Va.

MOTHER 14. Maiden Name Mattie Marie Chew

15. Birthplace Harmon, W. Va.

16 (a) Informant Mother

(b) Address 1009 Williams St., Balto., Md.

17 (a) ——— (b) Date thereof ———
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JAN 29 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 JAN 29 1945 Hunter Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26, 1945, at 10:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25/1945 to 1/26/1945, and that I last saw him alive on 1/26/1945.

Immediate cause of death Unknown
Probably pulmonary atelectasis — Duration

Due to

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles E. Cham[illegible], M.D.

Address Md. Genl. Hosp'l. Date signed 1/26/45

VS 150

F 2474

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registration No. G25269

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8 Hadley Square
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Hadley Square
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philip F. Schwaab Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-09-7843

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Catherine R. Schwaab

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1900

8. AGE: Years 44 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Engineer Mechanical

11. Industry or business

FATHER
12. Name Philip F. Schwaab Sr.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Caroline Wendel
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Catherine R. Schwaab
(b) Address 8 Hadley Square

17 (a) Burial (b) Date thereof 1-31-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) JAN 29 1945 Huntington Williams, M.D.
(Date received by local registrar) (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28, 1945, at 2.30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27, 1945, to Jan. 28, 1945, and that I last saw him alive on Jan. 28, 1945

Immediate cause of death	Duration
Coronary Occlusion	Immediate
Due to ?	
Due to ?	
Other Conditions None.	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None.

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank M. Ogden M. D.
Address 2701 N. Calvert St. Date signed Jan. 29, 1945

X

G25270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G25270
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2123 W Baltimore st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 W Baltimore (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah E Schirmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John J

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21 1866

8. AGE: Years 78 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Frank H Lutz
13. Birthplace Penna

MOTHER
14. Maiden Name Margaret Conner
15. Birthplace Penna

16 (a) Informant Mrs M. Ellenberger
(b) Address 2123 W Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Geo A Farley
(b) Address Fulton & Fayette

19 (a) JAN 29 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1945, at 4 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to Jan 1945, and that I last saw h[illegible] alive on Jan 29 1945.

	Duration
Immediate cause of death Coronary thrombosis	2 days
Due to Hypertension & Arteriosclerotic V. Disease	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F Carahan M. D.
Address 24 N. Fulton Ave Date signed 1/27/45

VS 150

625271 625271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 170 c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name of town)
(d) Street No. 4289 S Gilmor Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles C Reynolds Reynolds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 1883

8. AGE: Years 61 | Months 11 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Bucks Md
(Town, county, and state)

10. Usual Occupation Hucksters

11. Industry or business

FATHER
12. Name James C Dody
13. Birthplace Md

MOTHER
14. Maiden Name Eliz. Dody
15. Birthplace Md

16 (a) Informant Mrs Laura Dowlin
(b) Address 4289 S Gilmor St

17 (a) Burial (b) Date thereof 2-1-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location Harford Rd Bare Md

18 (a) Funeral director Guy C Talley
(b) Address Fulton & Fayette

19 (a) (b) Huntington Pettigrew, M.D.
(Date received by registrar) Registrar

W 23 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1945 at 1 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Jan 29 1945 at 20-5 M.
(b) Where did injury occur? Wilkens Ave & Wilkens Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian struck

23. Signature Robert Gilbert Graham M.D.
Medical Examiner.
Date signed Jan 29 1945

X

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G25272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G25272

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 S Hanover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 621 S Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Norinsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Esther Nee Israel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1897

8. AGE: Years	Months	Days	If less than one day
47	7	18	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Grocer Business

FATHER
12. Name Charles Norinsky
13. Birthplace Russia

MOTHER
14. Maiden Name Jennie Marks
15. Birthplace Russia

16 (a) Informant Mr Abe Norinsky
(b) Address 621 S Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof January 30, 1945 (month) (day) (year)
(c) Cemetery or crematory Anshei Emunah Cong
Location Hebrew Washington Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) 1/29/1945 (b) Huntington Williams, Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1945 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10 1944 to 1/28 1945, and that I last saw h[illegible] alive on 1/28 1945.

Immediate cause of death Coronary Thrombosis — Duration 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Frankel M. D.
Address 1111 Sea Date signed 1/29/45

VS 150

G25273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. G25273

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 513 N. CHESTER ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 BURNETT ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET LEHN

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	WIDOW

6 (b) Name of husband or wife ANDREW F LEHN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 30 1864

8. AGE: Years	Months	Days	If less than one day
80.	2	29	hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)
10. Usual Occupation HOUSE WORK.
11. Industry or business -AT- HOME

FATHER
12. Name SIGMUND HABSELBERGER
13. Birthplace GERMANY

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace

16 (a) Informant FERDINAND LEHN
(b) Address 3229 DUDLEY AVE

17 (a) BURIAL (b) Date thereof FEB 1-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location O.A.C.

18 (a) Funeral director Barnard C Harke
(b) Address 124 E West St
(b) Huntington Williams M.D.
JAN 30 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 29th 1945, at 2:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945 to Jan 29 1945, and that I last saw h[illegible] alive on Jan 26 19 45

Immediate cause of death Thrombosis Coronary Arteries — Duration

Due to

Due to

Other Conditions Arterio Sclerosis Hypertension

(Including pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John C. Schwartz M. D.
Address 1337 E. Chase St. Date signed 1/29/45

VS 150

625274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

625274 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 119 S. Ann St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 S. Ann St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Janka

3 (b) If veteran, name war

3 (c) Social Security Account No. No

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Henry A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1866

8. AGE: Years 78 | Months 4 | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name ?

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Anna ?

MOTHER 15. Birthplace Germany

16 (a) Informant Eva Siminski

(b) Address 119 S. Ann St.

17 (a) burial (b) Date thereof 1/30/1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location German Hill Rd.

18 (a) Funeral director M. W. E. Dippel's Sons

(b) Address 409 Bond & Ann Sts.

19 (a) JAN 30 1945 (b) Huntington Williams Registrar
(Date filed by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1945, at 5:13 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1945 to January 26 1945, and that I last saw h.w. alive on January 25 1945.

Immediate cause of death Lobar Pneumonia — Duration 6 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Silverstein M. D.

Address 22 S. Broadway Date signed Jan 27 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G65275 113 Registered G65275

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 35-03 Mt. Pleasant Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George O. Ellender

3 (b) If veteran, name war —

3 (c) Social Security Account No. 714-05-6928

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: w, dvcd

6 (b) Name of husband or wife: Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1887

8. AGE: Years 57 | Months 9 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business Beth. Steel Co.

FATHER
12. Name Geo. B. Ellender
13. Birthplace ?

MOTHER
14. Maiden Name Mary E. Green
15. Birthplace ?

16 (a) Informant Mrs. Josephine Schultz
(b) Address 602 Savage St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/45 (month) (day) (year)
(c) Cemetery or crematory N. Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Stephen J. Fiddemi
(b) Address 1001 S. Kenwood Ave.

19 (a) Date received 1-30-1945 (b) Registrar's signature for Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1945, at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Emphysema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed Jan 29 1945

625276
AB-91767

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

625276 ✓ Registered No. 122a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 17 ✓
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
566 Oxford St.
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Bessie Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1-1879

8. AGE: Years	Months	Days	If less than one day
65	10	25	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Norris (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Henson-or-Heson (D)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemt.
Location Cedar Hill Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) JAN 30 1945 (b) Huntington Williams, Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26- 1945 at 7.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-23 1945 to 1-26 1945, and that I last saw her alive on 1-26- 1945.

Immediate cause of death Autopsy not conclusive

Due to Post-Operative incarcerated ventral hernia

Due to

Other Conditions Hypertension & anemia
(Include pregnancy within 3 months of death)

Date of operation 1-24-45

Major findings of operation: as above

of autopsy: as above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature R. Butler M.D.
Address City Hosp Date signed 1-28-45

VS 150

625277 ✓ 625277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 223 Roebuck Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4608 Harford Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Blanche C. Ingalls

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
W	none	Female	White	Married

6 (b) Name of husband or wife George E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23 1872

8. AGE: Years	Months	Days	If less than one day
72	3	4	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name	Wm S. Chester
FATHER 13. Birthplace	Unknown
MOTHER 14. Maiden Name	"
MOTHER 15. Birthplace	"

16 (a) Informant George E. Ingalls
(b) Address 4608 Harford Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md
18 (a) Funeral director Gibson Co
(b) Address 1217 E. Fort Ave
19 (a) JAN 30 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1945, at 11:45 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Jan 27 1945 and that I last saw h. alive on Jan 26 1945

Immediate cause of death	Duration
Hypostatic Cerebro Vas Dis	1 yr
Due to Chr Nephritis	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Fritz J Bruyn M. D.
Address 7200 Harford Rd Date signed Jan 29 1945

Huntington Williams, M.D.

VS 150

625278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940

625278 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1336 N North Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1336 N North Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucas L Hardeman

3 (b) If veteran, name war: WWI

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mathilde

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 19 1871

8. AGE: Years 73 | Months 5 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Georgia
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name James A Hardeman

13. Birthplace Georgia

MOTHER 14. Maiden Name Nancy Benton

15. Birthplace Ga

16 (a) Informant Mathilde Hardeman

(b) Address 1336 N North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Tolson & Son

(b) Address 1217 E Cont St

19 (a) JAN 30 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1945 at 11:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1944 to 1/28 1945 and that I last saw h[illegible] alive on 1/25 1945

Immediate cause of death: Cardiac failure

Due to: Coronary thrombosis

Due to: Generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature D Shonfeld M.D.

Address 611 N Monroe St Date signed 1/29/45

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be especially important.

625279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

625279 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Ave.
(c) ~~Hospital or~~ institution: Home for the Aged of the M.E. Church
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William David T. Foster

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Lydia A. Foster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27th 1857

8. AGE: Years	Months	Days	If less than one day
87	10	1	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Inmate
11. Industry or business Home for Aged

FATHER
12. Name William Foster
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Sallie Shakling
15. Birthplace Balto. Co. Md.

16 (a) Informant Records - Methodist Home
(b) Address 2211 Rogers Ave

17 (a) Burial (b) Date thereof 1/30/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) (b) 45
(Date rec'd by registrar) Registrar

VS 150 JAN 30 1945 Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28th 1945 at 12 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944, to Jan 27, 1945, and that I last saw h/m alive on Jan 27 1945.

Immediate cause of death	Duration
Apoplexy.	2 hours
Due to Arteriosclerosis	20 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Arthur J. Davis M. D.
Address 800 N. Broadway Date signed 1-29-45

625280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93C

625280 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 766 McHenry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 766 McHenry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ira F Callinan

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26 1875

8. AGE: Years	Months	Days	If less than one day
69	7	2	hr. min.

9. Birthplace Pennsylvania Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Noah London
13. Birthplace Somerset Co Md

MOTHER
14. Maiden Name Annie Workman
15. Birthplace Va

16 (a) Informant Daniel Ringrose
(b) Address 766 McHenry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/45
(month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore Md

18 (a) Funeral director Wilson Funk
(b) Address 1217 E Fayette St

19 (a) (Date rec'd by registrar) (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1945, at 9:24 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 1918 to 1-27 1945.
and that I last saw h alive on 1-27 1945

Immediate cause of death	Duration
Cardiac Decay	3 Mos
Due to Myocarditis	4 Mos
Due to Hypertension	6 Mos
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hoyland Dunn M. D.
Address 766 McHenry St Date signed 1/29/45

G65281

AB-91714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G65281 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1928 Riggs Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Allen

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Minnie E.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 9-~~1866~~ 1874
8. AGE: Years ~~75~~ 70 | Months 3 | Days 18 | If less than one day ... hr. ... min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Howard Allen (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Charlotte (D)
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/45 (month) (day) (year)
(c) Cemetery or crematory Pinelawn Cemetery
Location Dundalk Md
18 (a) Funeral director Williams Lee Inc
(b) Address 1500 Pont St

19 (a) ... (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27- 1945, at 8.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20- 1945, to 1-27 1945, and that I last saw him alive on 1-27- 1945.

	Duration
Immediate cause of death: Carcinoma of Bladder	7
Due to	
Due to	
Other Conditions: Secondary Anemia	7

(Include pregnancy within 3 months of death)

Date of operation 1-24-45
Major findings of operation: Carcinoma of Bladder
of autopsy: Carcinoma of Bladder

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. J. Perry M.D.
Address BCH Date signed 1-29-45

(OVER)

G25282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G25282 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 S. Brunwidk Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 S. Brunswick St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Prevost

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Alphonse J.
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 30, 1863

8. AGE: Years: 81 | Months: - | Days: 29 | If less than one day: hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business

FATHER
12. Name: John Coleman
13. Birthplace: unknown

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Alphonse Prevost
(b) Address: 507 S. Brunswick St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 1/31/45 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore

18 (a) Funeral director: William C ook, Inc.
(b) Address: 1217 St. Paul Street

19 JAN 30 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/28 1945 at 8:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to Jan 28 1945 and that I last saw her alive on 1/28 1945

Immediate cause of death: Myocardeal defarct | Duration: 1 Mo

Due to:

Due to:

Other Conditions: General Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 336 Frederick Ave Date signed 1/29/45

VS 150

625283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93C

625283 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3405 Greenway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3405 Greenway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie B Selden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. ~~Sex~~ Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles Selden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27/1855

8. AGE: Years 89 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace Dayton Ohio (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Aaron Stork
13. Birthplace Phila Pa.

MOTHER
14. Maiden Name Nancy Musser
15. Birthplace Marion Ohio

16 (a) Informant Imogen D. Selden
(b) Address 3405 Greenway

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Feby 1/1945 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto Md

18 (a) Funeral director Harry T. Amacost
(b) Address 4204 Redgewood Ave

19 (a) (b)
(Date rec'd by registrar) Registrar
JAN 30 1945 Hamilton Fox Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1945 at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1944 to Jan 28 1945 and that I last saw h[illegible] alive on Jan 28 1945.

Immediate cause of death Myocarditis — Duration 6 months

Due to Arthritis Deformans — 9 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. Conrad Bodd M. D.

Address 1900 Maryland Ave Date signed 1-29-45

X

G5284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G5284

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1250 Riverside Av.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1250 Riverside
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Litzau

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1/28/45

8. AGE: Years | Months | Days | If less than one day 10 hrs min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Karl Litzau
13. Birthplace A.A. County

MOTHER
14. Maiden Name Josaphine Calvert
15. Birthplace A.A. County

16 (a) Informant Mr Carl Litzau
(b) Address 1250 Riverside Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/45 (month) (day) (year)
(c) Cemetery or crematory Friendship Cem.
Location Campmead Rd.

18 (a) Funeral director L. Heemann's Son
(b) Address 32 S. Broadway

19 (a) JAN 30 1945 (b) Waiting for Williams M.P.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1945 at 7.15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1945 to Jan 28 1945 and that I last saw her alive on Jan 28 1945.

Immediate cause of death Albert Thomas — Duration
Coma
Due to
Due to
Other Conditions Fracture Femur
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. Rebert M.D.
Address C. Date signed 1/30/45

VS 150

65285

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 181

65285 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Monument
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 East (Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SHIRLEY FLETCHER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 26, 36

8. AGE: Years 8 | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace BALTIMORE
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jos W. Fletcher
13. Birthplace BALTO.

MOTHER
14. Maiden Name RATH. OSTENDORF
15. Birthplace BALTO.

16 (a) Informant Mrs. Fletcher LANDLADY
(b) Address 1618 E BALTO.

17 (a) BURIAL (b) Date thereof 1/30/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE

18 (a) Funeral director L. HEEMANN'S SON
(b) Address 32 S. BROADWAY.

JAN 30 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1945, at 5:18 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Enquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gun Shot Wound 31d° Burns 85% of body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/27/45 at 10:40 A.M. 6/5
(b) Where did injury occur? 1618 East Baltimore
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Burned from Kerosene

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 1/28/45

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

Registered No. 625286

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
COUNTRY - TRINIDAD
(a) ~~State~~ (b) County
(c) City or town C Laguana Main Rd. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Trinidad

3 (a) FULL NAME Charles Ramesar

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Elfrida Ramesar
6 (c) If alive, give age 41 years
7. Birth date of deceased (mo., day, yr.) 6-3-98
8. AGE: Years 46 | Months 7 | Days 25 | If less than one day ..... hr. ..... min.
9. Birthplace Trinidad (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name David Ramesar
13. Birthplace India

MOTHER
14. Maiden Name Ethel Sundriak
15. Birthplace India

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 15/45 (month) (day) (year)
(c) Cemetery or crematory Trinidad B.W.I.
Location Trinidad South America

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1910 Eutaw Place

19 (a) JAN 30 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1945, at 7½ M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11 1945, to Jan. 28 1945, and that I last saw him alive on Jan. 28 1945.

Immediate cause of death Heart failure

Due to pneumonia

Due to left diaphragmatic hernia

Other Conditions mild diabetes

(Include pregnancy within 3 months of death)

Date of operation 1-25-45

Major findings of operation: Kidneys, spleen & liver within on chest & diaphragm see

of autopsy:

Duration: 2 yrs. 3 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Burnley M. D.
Address J. H. H. Date signed 1-28-45

625287 467578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. 625287

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Hampton House N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Christine M. Dick

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-19-71

8. AGE: Years	Months	Days	If less than one day
73	8	10	hr. min.

9. Birthplace Canada. (Town, county, and state)

10. Usual Occupation Registered Nurse

11. Industry or business

FATHER 12. Name Alexander Dick

13. Birthplace Scotland

MOTHER 14. Maiden Name Elizabeth Chisholm

15. Birthplace Canada

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1. 45 (month) (day) (year)

(c) Cemetery or crematory Brampton Cem

Location Brampton Ontario

18 (a) Funeral director John O. Butterfield & Sons

(b) Address 1906 Eutaw Place

19 JAN 30 1945 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan-29 1945, at 3.35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-20 1945 to Jan-29 1945 and that I last saw him alive on Jan-29 19

Immediate cause of death: Intestinal Obstruction + Fecal Fistula — Duration: 10 days

Due to: Post Operative Adhesions — Duration: 1 day

Due to

Other Conditions: Arteriosclerotic Heart Disease (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Adhesions & Intestinal Obstruction

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan C. Woods Jr.

Address John Hopkins Hospital Date signed 1/29

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46D Registered No. 25288

25288

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered, correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md. (If outside city or town limits, write county here and give town)
(d) Street No. 2502 Eutaw Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Mary A. Beck (Mary A. Beck)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband ~~or wife~~
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/29/72
8. AGE: Years 72 Months 5 Days 29 If less than one day hr. min.
9. Birthplace Phila. Pa. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Solomon Aarons
13. Birthplace England

MOTHER
14. Maiden Name Rachel De Nobf
15. Birthplace England.

16 (a) Informant Mr. Sol Beck,
(b) Address Emerson Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/45 (month) (day) (year)
(c) Cemetery ~~cremation~~, Hebrew Friendship
Location Balto. Md.

18 (a) Funeral dir. Louis Levinson & Son
(b) Address 1902 Eutaw Place

19 (a) JAN 30 1945 (Date received by local registrar) (b) Huntington Wills Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/28/45 19 , at 2 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from 1/22/45 19 , to 1/28/45 19 , and that I last saw her alive on 1/27/45 19

Immediate cause of death	Duration
Acute Generalized Peritonitis	
Due to Perforation of Rectum	
Due to Carcinoma of Rectum.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frances L. Greenline M. D.
Address Bon Secours Hosp. Date signed 1/29/45

G25289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G25289 Registered No.

JO #88199

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos. 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3127 Elliott St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Kitko

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-01-2143

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Edward Kitko
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1919

8. AGE: Years	Months	Days	If less than one day
25	7	13	hr. min.

9. Birthplace New York
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Andrew Panciszon (d)
13. Birthplace Poland

MOTHER
14. Maiden Name Victoria Krysko
15. Birthplace Poland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) B (Burial, cremation, or removal) (b) Date thereof 2-1-45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Sherman Hill Rd

18 (a) Funeral director John J. Fudy
(b) Address 2829 Hudson st

19 (a) (Date rec'd by registrar) (Registrar) Huntington Williams M.D.

JAN 30 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1945, at 11A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 24, 1944, to Jan. 28, 1945, and that I last saw her alive on Jan. 28, 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	5 yrs.
bilateral	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto City Hosp. Date signed 1/29/45

625230 — BALTIMORE CITY HEALTH DEPARTMENT — 85 — 625230

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2711 Fait Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2711 Fait Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME IRENE JOSEPHINE SADTLER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	Single

6 (b) Name of husband or wife L

6 (c) If alive, give age 19 years

7. Birth date of deceased (mo., day, yr.) Oct. 3 ~~1925~~

8. AGE: Years	Months	Days	If less than one day
~~2~~ 25	3	24	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Andrew Sadtler
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Anna Marshall
15. Birthplace Baltimore Md.

16 (a) Informant Andrew Sadtler
(b) Address 2711 Fait ave.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 1-31-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John J Fuda
(b) Address 2829 Hilldrop St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 1[illegible] JAN 30 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1945 at 8:20 P.M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
States Epilepticus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed Jan 30, 1945

over

625291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 23

625291 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2200 Roslyn ave
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 Roslyn ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas B. Miller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 31 1868

8. AGE: Years	Months	Days	If less than one day
76	11	29	hr. min.

9. Birthplace Westminster, Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Geo. W. Miller
13. Birthplace Md.

MOTHER
14. Maiden Name Charity Brown
15. Birthplace Md.

16 (a) Informant Miss Maude Miller
(b) Address 2200 Roslyn ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Westminster Cem.
Location Westminster, Md.

18 (a) Funeral director J. Francis Reese
(b) Address Westminster, Md.

19 (a) (Date rec'd by Registrar) (b) Filed Feb 1 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1945, at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to Jan 29 1945 and that I last saw him alive on Jan 29 1945.

Immediate cause of death	Duration
Myocardial insufficiency	2 wks
Severe bronchopneumonia	2 wks
Due to Gastro-intestinal hemorrhage - recurring.	
Due to Cancer Jan 15, 1945	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carroll Sickard M. D.
Address 2925 N. Charles St Date signed Apr 4 45

VS 250

G25292 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH 108 — G25292

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 632 W Saratoga St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 632 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geraldine Bowman.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Separated

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5-13-1921

8. AGE: Years	Months	Days	If less than one day
23	8	14	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business

FATHER
12. Name James Bowman
13. Birthplace N. C.

MOTHER
14. Maiden Name Vivian Wilson
15. Birthplace N. C.

16 (a) Informant Vivian Wilson Pernell
(b) Address 632 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) (Date rec'd by registrar) JAN 30 1945 (b) Huntington & Williams, Inc

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1945, at 11:5 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1945, to Jan 27 1945, and that I last saw h[illegible] alive on Jan 26 1945.

Immediate cause of death Acute Pneumonia — Duration 3 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify)
(e) Means of injury

23. Signature J. H. Stewart M. D.
Address 632 Pinkney St Date signed Jan 30

BALTIMORE CITY HEALTH DEPARTMENT ✓ G25293 Registered No.

CERTIFICATE OF DEATH 83a

G25293

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 818 N. Mount St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 818 N. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rev. Jacob A. Baytop

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rachel

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1879

8. AGE: Years: 66 | Months | Days | If less than one day: hr. | min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Clergyman

11. Industry or business

FATHER
12. Name: Jacob Baytop
13. Birthplace: Va.

MOTHER
14. Maiden Name: Caroline ?
15. Birthplace: Va.

16 (a) Informant: Theodore Baytop
(b) Address: 635 N. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-31-45 (month) (day) (year)
(c) Cemetery or crematory: Mt Auburn Cem
Location: Balto-Md

18 (a) Funeral director: William A. Jackson
(b) Address: 916 Penna. Ave.

19 (a) (Date received by local registrar) JAN 30 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1945 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27 1941 to Jan 27 1945 and that I last saw him alive on Jan 27 45

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 Day

Due to: Hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: C. H. Pickett M.D.
Address: 536 W Lanvale St. Date signed: 1-29-45

X

✓ G25294

G25294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully st... correct age is especially important. Physicians: please write the c... the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2302 Druid Park Drive

(c) Hospital or institution:

15th

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2302 Druid Park Drive (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME John William Koehne

3 (b) If veteran, name war: 1st World

3 (c) Social Security Account No. 214-12-1213

4. Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Loraine B. Koehne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9-1896

8. AGE: Years 49 | Months - | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county and state)

10. Usual Occupation Machinist

11. Industry or Business Fries & Steinmyer

FATHER

12. Name William C. Koehne

13. Birthplace Maryland

MOTHER

14. Maiden Name Matilda Myers

15. Birthplace Maryland

16 (a) Informant Mrs. Loraine B. Koehne

(b) Address 2302 Druid Park Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 31. 1945 (month) (day) (year)

(c) Cemetery or Crematory Druid Ridge

Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Fredello Road

19 (a) JAN 30 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28- 1945, at 2.45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25- 1944 to Jan 28 1945 and that I last saw h... alive on Jan 28 1945

Immediate cause of death Cardiac Asthma — Duration 3 da.

Due to Pulmonary Tuberculosis — 5 yrs.

Due to Secondary Anemia — 3 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E W Koons M.D.

Address 1202 E. Paul St. Date signed Jan 29/45

X

625295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161Q

Registered No. 625295

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2105 St. Paul St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl Feddon, Katherine May

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 25, 1945

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (b) Date thereof Jan 30 1945

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director Frederick A. Cole

(b) Address 1700 W Lombard St

19 (a) (b) Huntington Williams, Md.

(Date rec'd by registrar) Registrar

JAN 30 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/28/45, at 12:48 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1945 to 1/28 1945, and that I last saw her alive on 1/28 1945.

Immediate cause of death Massive Pulmonary Atelectasis, bilateral — Duration

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Pulmonary Atelectasis, bilateral

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Charles S. Shaw, Jr. M.D.

Address Md. Gen'l. Hospl. Date signed 1/29/45 M. D.

X

625296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

625296 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2623 Greenmount
(c) Hospital or institution:
Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2623 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Seggie

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-10-2190

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Ethel Seggie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
? 51			hr. min.

9. Birthplace Lonaconing Md
(Town, county and state)
10. Usual Occupation Ship builder
11. Industry or business

FATHER
12. Name John L. Seggie
13. Birthplace Frostburg Md

MOTHER
14. Maiden Name Sarah Fountain
15. Birthplace Frostburg

16 (a) Informant Ethel Seggie
(b) Address Frostburg

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1, 45 (month) (day) (year)
(c) Cemetery or crematory
Location Frostburg Md.

18 (a) Funeral director A. R. Glade
(b) Address 4907 York Rd

19 (a) JAN 30 1945 (b) Registrar
(Date received by Registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1945, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Richard A. Graham M.D.
Medical Examiner.
Date signed 1-29-45

VS 151

297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G25297

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 W. 39th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 W. 39th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DOUGLAS GORMAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-6920

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Gwendolen Nash Gorman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1882

8. AGE: Years	Months	Days	If less than one day
62	8	16	hr. min.

9. Birthplace Annapolis, Md.
(Town, county, and state)
10. Usual Occupation President
11. Industry or business Cumberland Coal Co.

FATHER
12. Name Wm. H. Gorman
13. Birthplace Woodstock, Md.

MOTHER
14. Maiden Name Mary Clark
15. Birthplace Clarksville, Md.

16 (a) Informant Mrs. Douglas Gorman
(b) Address 102 W. 39th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/45 (month) (day) (year)
(c) Cemetery or crematory St. Thomas Cem.
Location Garrison Forest

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 30 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29, 1945, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1942 to Jan 29 1945 and that I last saw h[illegible] alive on Jan 29 1945.

Immediate cause of death Cardiac Decompensation
Myocarditis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A Baetzer M. D.
Address 1115 St Paul St Date signed 1/29/45

VS 150

625298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 625298 / 1637

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3111 Virginia Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3111 Virginia Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA P. WINTERS

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/2/1891

8. AGE: Years	Months	Days	If less than one day
53	7	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name J. William Winters
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elvira E. Lewis
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Blanche Winters, Sister
(b) Address 3111 Virginia Ave.

17 (a) Burial (b) Date thereof 1/31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 30 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29, 1945, at 4:20 p. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon Monoxide Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 29 at 27/16 4:P M.
(b) Where did injury occur? Home
(c) Did injury occur at home, on farm, industrial place, in public place? Heating in bathroom While at work?
(d) Means of injury Carbon Monoxide Poisoning

23. Signature John L. Davis M.D.
Medical Examiner.
Date signed January 30, 1945

P 395-08

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 625299

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 N. Gilmore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Hughes Blackwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6 1944

8. AGE: Years | Months: 1 | Days: 21 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Otis Hughes
13. Birthplace S. C.

MOTHER
14. Maiden Name Dorothy Blackwell
15. Birthplace N.C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 30, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St.

JAN 30 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1945, at 9 35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26- 1945 to 1-27 1945 and that I last saw him alive on 1-27- 1945

Immediate cause of death: respiratory failure — Duration

Due to: bronchiolitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert Kaye M. D.

Address 1466 Date signed 1-28-45

625300

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1310

1. PLACE OF DEATH — Registered No.

CITY OF BALTIMORE: (No. 509 N. Carey St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 23 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME William Thos Jones

(a) Residence: No. 509 N. Carey St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) 1888

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Grocer —

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) D. C.

FATHER

13. NAME Spencer Price

14. BIRTHPLACE (city or town) (State or country) D. C.

MOTHER

15. MAIDEN NAME Dexter Simms

16. BIRTHPLACE (city or town) (State or country) D. C.

17. INFORMANT Martin Price

(Address) 509 N. Carey St

18. BURIAL, CREMATION, OR REMOVAL

Place Arbutus Memorial Date Jan 30, 1945

19. UNDERTAKER Mrs Katie R. Williams

(Address) 322 S. Schroeder St.

20. FILED JAN 30 1945 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan 26, 1945

22. I HEREBY CERTIFY, That I attended deceased from June 5, 1944 to June 26, 1944

I last saw h alive on Jan 26, 1945 Death is said to have occurred on the date stated above, at 4:30 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
a Uraemia	
b Chronic Nephritis	
c Hypertension	
d Chr Valvular Cardiac	

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) David Trumbull M.D.

(Address) Irvington

V. S. 3

Information should be carefully supplied. Age must be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G25301

AB-91705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. G25301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days): 8days

(e) Length of stay in Baltimore (yrs., mos., or days): 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County:

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No.: 625 S. Charles St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME: Samuel Pollard or Simon Pollit

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Dottie

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 15- 1904

8. AGE: Years: 40 Months: 10 Days: 13 If less than one day: hr. min.

9. Birthplace: Ga. (Town, county, and state)

10. Usual Occupation:

11. Industry or business:

FATHER

12. Name: Solmon Pollard

13. Birthplace: ?

MOTHER

14. Maiden Name: Henrietta Reynolds

15. Birthplace: Ala.

16 (a) Informant: Baltimore City Hospitals (Records)

(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-45 (month) (day) (year)

(c) Cemetery or crematory: Mt Calvary

Location:

18 (a) Funeral director: James A. Hayes

(b) Address: 1412 W. Fayette St.

JAN 30 1945 (Date rec'd by registrar)

(b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 28- 1945, at 3.10AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20- 1945, to 1-28 1945, and that I last saw him alive on 1-28 1945.

Immediate cause of death: Respiratory failure — Duration:

Due to: Pulmonary Tuberculosis — Duration: Unknown

Due to:

Other Conditions: Tuberculous Meningitis (?)

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: Sue Edwards M. D.

Address: Baltimore Md. Date signed 1-27-45

VS 150

X

G25302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G25302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2305 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) P
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ellen Ryan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1860

8. AGE: Years	Months	Days	If less than one day
84	2	8	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter Harris
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mrs. Hester Floyd
(b) Address 2305 Madison Ave.

17 (a) Burial (b) Date thereof 2-1-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JAN 30 1945 (b) Huntington Williams
(Local registrar or deputy)

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH Jan. 28, '45 19 , at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1944 to Jan 28 1945 and that I last saw h alive on Jan 28 1945

Immediate cause of death

Mitral Insufficiency — Duration 7

Due to —

Due to

Other Conditions Senility — Duration —

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation

of autopsy? None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S B Hughes M.D.
Address 1413 Druid Hill Ave Date signed Jan 29 1945

625303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 625303

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & London
(c) Hospital or institution: Md. Gen. Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 566 N. Mary's St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William G. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1873

8. AGE: Years	Months	Days	If less than one day
71	2	11	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name William A. Smith
13. Birthplace Virginia

MOTHER
14. Maiden Name Sylvia Smith
15. Birthplace Virginia

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JAN 30 1945 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29 1945, at 1:43 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 20 1945, to Jan. 29 1945, and that I last saw him alive on Jan. 29 1945.

Immediate cause of death Coronaria, Decompensation — Duration

Due to

Due to

Other Conditions Carcinoma of Sigmoid 3rd day post operative - Cholecystectomy

(Include pregnancy within 3 months of death)

Date of operation Jan. 26, 1945

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. L. McCormack M. D.
Address Date signed 1-30-45

95 C

625304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G25304

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 Gold Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 - 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Gold Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marcissia Berry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1892

8. AGE: Years	Months	Days	If less than one day
52	2	18	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Richard Childs
13. Birthplace Va.

MOTHER
14. Maiden Name Katie Dickerson
15. Birthplace Val

16 (a) Informant M's Virginia Childs
(b) Address 504 Gold Street

17 (a) Burial (b) Date thereof 1-31-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Milford, Caroline Co., Va.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JAN 30 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Jan 27, '45 19 , at 11:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 '45 to 1/27 19 45
and that I last saw h alive on 19

Immediate cause of death	Duration
Diabetes	
Due to Cerebral Apoplexy	
Due to Paralysis	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dan'l Griffin M.D.
Address 83a Date signed 1/29/45

Dr. Zimmerman
2858 Harford Rd.

G25305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G25305

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4230 Stanwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4230 Stanwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin C. Powley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife Theresa A. Powley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1859

8. AGE: Years	Months	Days	If less than one day
86	--	20	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Edwin Powley
13. Birthplace Baltimore Co.

MOTHER
14. Maiden Name Elmira Powley
15. Birthplace Baltimore Co.

16 (a) Informant Mr. George Coleman
(b) Address 4230 Stanwood Avenue #13

17 (a) Burial (b) Date thereof 1/30/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) Filed JAN 30 1945 Hattie [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1945, at 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1944 to Jan 27 1945, and that I last saw h[illegible] alive on Jan 27 1945.

Immediate cause of death	Duration
Arteriosclerosis	15 d
Due to —	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ed. C. Zimmerman M.D.
Address 2858 Harford Rd Date signed 1/29/45

625306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1943

Registered No. 625306

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 229 N. Parrish St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Brown, JR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DECEMBER 24, 1889

8. AGE: Years	Months	Days	If less than one day
56 55	1	4	hr. min.

9. Birthplace GEORGETOWN DC
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name GEORGE BROWN, SR.
13. Birthplace GEORGETOWN DC

MOTHER
14. Maiden Name
15. Birthplace GEORGETOWN DC

16 (a) Informant IKE M. SAMPLE
(b) Address 201 N. PARRISH ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1 1943 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Baltimore County

18 (a) Funeral director Joseph A. Lowe
(b) Address 409 N. Mount Street

19 (a) Date received JAN 30 1943 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/28 1943, at 2:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry, and from the evidence obtained by said Autopsy, Inspection or Inquiry find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature E. J. Lubinski M.D.
Medical Examiner.
Date signed 1/30/43

VS 151

G25307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13D

Registered No. G25307

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1107 Russell St 21
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 N. Carrollton Ave 1107 Russell (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Effie Tillman

3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race Colored
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 1, 1907
8. AGE: Years 37 Months 9 Days 25 If less than one day hr. min.
9. Birthplace Anderson Co N.C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name William Tillman
13. Birthplace Anderson N.C.

MOTHER
14. Maiden Name Not Known
15. Birthplace

16 (a) Informant George Tillman
(b) Address 1107 Russell St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City
18 (a) Funeral director Joseph A Lively
(b) Address 1708 Mount street
19 (a) JAN 30 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1945 at 12.10 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Jany 12 1945 to Jany 27 1945 and that I last saw h[illegible] alive on Jan 27 1945
Immediate cause of death Pulmonary Tuberculosis — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature W. B. Rogers M. D.
Address 607 N Carrollton Ave Date signed 1/29/45

G25308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. G25308

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Kent Co.
(c) City or town Worton
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mary Harper Harris

3 (b) If veteran, name war.....

3 (c) Social Security Account No.....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Walter B. Harris
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7-26-84.

8. AGE: Years	Months	Days	If less than one day
60	6	4	..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George W. Harper
13. Birthplace Del.

MOTHER
14. Maiden Name Mary Gale
15. Birthplace Md.

16 (a) Informant Meads.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 3/45 (month) (day) (year)
(c) Cemetery or crematory Still Pond
Location Still Pond Md

18 (a) Funeral director P R Fellows
(b) Address Still Pond Md

19 (a) JAN 30 1945 (Date rec'd by registrar) (b) Huntington Williamsville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30 1945, at 8:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13 1944, to 1-30 1945, and that I last saw h[illegible] alive on 1-30 1945.

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to Anemia	
Due to Acute Myeloid Leukemia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Ross L. McLean M. D.
Address J. H. H. Date signed 1-30-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310 Registered No. 625309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1422 Hopewell Ct
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 Hopewell Ct
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrance Broomskin

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-16-0404

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	colored	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10 1912

8. AGE: Years	Months	Days	If less than one day
33	-	18	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Robert Broomskin
13. Birthplace Va

MOTHER
14. Maiden Name Florence Jackson
15. Birthplace Va

16 (a) Informant Florence Broomskin
(b) Address 1422 Hopewell Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director George S. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) JAN 30 1945 (Registrar) Registrar
Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1945, at 1230 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1945, to Jan 28 1945, and that I last saw h[illegible] alive on Jan 28 1945.

Immediate cause of death	Duration
Cardio Vascular Renal Disease	?
Due to Uremia	5 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. William Frey M. D.
Address 1928 Pa Ave Date signed 1/29/45

X

G65310 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH — 1945 B — Registered No. G65310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 S. Potomac St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 S. Potomac St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emmett F. DeanDeem

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years	Months	Days	If less than one day
35			hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Brakeman
11. Industry or business Sparrows Point

FATHER
12. Name Benjamine F. Deem
13. Birthplace W. Va

MOTHER
14. Maiden Name Lillie Maloy
15. Birthplace Ohio

16 (a) Informant Mrs Katherine Deem
(b) Address 1114 S. Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1st 1945 (month) (day) (year)
(c) Cemetery or crematory Morelands Memorial
Location Gaylor Ave

18 (a) Funeral director J. 701-03 N. Pattison Park Ave
(b) Address Lee G. Leach Funeral Home

19 (a) JAN 30 1945 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30 1945, at 1.00 A M

21. I certify that I took charge of the remains described above, held an Enquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Angina Pectoris.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.
Date signed 1/30/45.

311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

Registered No. 625311

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1427 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Chase

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: B | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/10/44

8. AGE: Years | Months: 1 mo | Days: 19 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Chappell
13. Birthplace Md.

MOTHER
14. Maiden Name Bernice Chase
15. Birthplace Md.

16 (a) Informant Bernice Chase
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JAN 30 1945

18 (a) Funeral director Commissioner of Health
(b) Address

JAN 30 1945 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29- 1945, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28 1945 to 1-29 1945, and that I last saw him alive on 1-29 1945.

Immediate cause of death Resp failure | Duration
Due to Prematurity, dehydration
Due to Intestinal obstruction
Stenosis hernia Rt.
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 1-27-45
Major findings of operation: adhesions
of autopsy: Hypoplasia lungs (obstructive)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas G. Ethan M. D.
Address Univ. Hospital Date signed 1-29-45

VS 150

2430

X

312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 65a

Registered No. 62312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and recorded. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County St. Marys
(c) City or town Leonardtown, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mike Tsamples

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Tsamples
13. Birthplace Finland

MOTHER 14. Maiden Name Rosa Mysicnen
15. Birthplace England

16 (a) Informant Self.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JAN 30 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 30 1945 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27 1945, at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13 1945 to 1-27 1945 and that I last saw him alive on 1-27 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Cardiac failure	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Complete Autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O M Simons M. D.
Address Univ. Hosp. Date signed 1-29-45

VS 150

2479

625313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1180

625313 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Broadway
(c) Hospital or institution: John Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 North East Street (Locate give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD WHITE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Ella White
(b) Address 112 East st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 31 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn A.R.C

18 (a) Funeral director Ida Bailey
(b) Address 1421 E. Jefferson

19 (a) JAN 30 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1945, at 2.50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Enquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Burns - 2nd & 3rd ° 20 % of body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 28, 1945 10:08 A.M.
(b) Where did injury occur? Home 112 North East Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Fire

23. Signature John R Davis M.D.
Medical Examiner.
Date signed January 29, 1945

VS 151

G25314 467487 TILLMOND G25314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Be sure that correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 McDonough St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick Tillmond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-16-97

8. AGE: Years	Months	Days	If less than one day
47	11	13	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Andrew Tillmond
13. Birthplace Va.

MOTHER 14. Maiden Name Elizabeth Jones
15. Birthplace Va

16 (a) Informant Rennda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Notified (Burial, cremation, or removal) (b) Date thereof 2-1-45 (month) (day) (year)
(c) Cemetery or crematory Fall Church
Location Virginia

18 (a) Funeral director Mrs Ida P Bailey
(b) Address 1721 Jefferson St

19 (a) JAN 30 (Date rec'd by registrar) (b) 1945 Registrar

Interment for Williamsburg

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan-29 1945, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-18 1945 to Jan-29 1945 and that I last saw him alive on Jan-29 1945.

Immediate cause of death	Duration
Heart failure	
Due to Syphilitic heart disease with aortic insufficiency	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus M.D.
Address Johns Hopkins Hosp Date signed 1/30/45

625315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178X

625315 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bond Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Hanover St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Jack Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1941

8. AGE: Years 3 | Months 6 | Days 30 | If less than one day hr. min.

9. Birthplace Miami, Florida (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jack Adams
13. Birthplace Atlanta, Ga.

MOTHER
14. Maiden Name Lillian Eslin
15. Birthplace Balt., Md.

16 (a) Informant Jack Adams
(b) Address 1424 Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Oakleys
Location Butler Md

18 (a) Funeral director C. Pascal Evans
(b) Address 1426 Scherman St

19 (a) Jan 30 1945 (Date received by registrar) (b) Registrar
Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29, 1945, at 7 15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute tracheitis and Bronchitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-27-45 at 23/1 11 30 P.M.
(b) Where did injury occur? 1424 Hanover St
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Inhaled smoke

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed Jan 30 1945

G25316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178X

G25316 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Patricia a. adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Defiant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19 1942

8. AGE: Years 2 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Florida Miami (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jack Adams
13. Birthplace Atlanta, Ga.

MOTHER 14. Maiden Name Lillian Eadon
15. Birthplace Baltimore, Md.

16 (a) Informant Jack Adams
(b) Address 1424 Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Oakland
Location Balto Md

18 (a) Funeral director G. Howard Evans
(b) Address 1400 Light St

JAN 30 1945 (Date rec'd by registrar) by Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1945, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Suffocation
due to acute (membranous) tracheitis and bronchitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-28-45 at M.
(b) Where did injury occur? 1424 Hanover Street
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Inhalation of smoke over

23. Signature Robert La Gratta M.D. Medical Examiner.
Date signed Jan 29 1945

A 19159
G25317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/13B

G25317
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1643 Barnes St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Osie Floris Hursey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1942

8. AGE: Years	Months	Days	If less than one day
3			hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Robert Johnson
13. Birthplace ?

MOTHER
14. Maiden Name Doris Hursey
15. Birthplace Md.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 31 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Elroy D. Wilson

18 (a) Funeral director
(b) Address 1000 Bradshaw ave

19 (a) JAN 30 1945 (Date rec'd by registrar) (b) Huntington Nuttall, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Jan - 28 1945, at 2 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24- 1944 to 1-28- 1945, and that I last saw her alive on 1-28- 1945.

Immediate cause of death: Asphyxia Pulmonal — Duration
Due to: Tbc meningitis
Due to:
Other Conditions: Pertussis Tbc
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Kaup M. D.
Address 1 Date signed 1-29-45

625318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

482

625318

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1755 Orleans St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1755 Orleans St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Ford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1890

8. AGE: Years 55 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Warrenton Va
(Town, county, and state)

10. Usual Occupation dom.

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name Sarah —
15. Birthplace Va

16 (a) Informant Mrs. C. Biggs
(b) Address 1755 Orleans St

17 (a) Burial (b) Date thereof 2/1/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Thomas E. Watson
(b) Address 1000 Bridgeley Ave

JAN 30 1945
(Date rec'd by registrar)

(b) Huntington Williams Undertaker

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1.30 1945 at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1945 to 1/30 1945 and that I last saw h.. alive on 1/29 1945.

Immediate cause of death Carcinomatosis — Duration

Due to Carcinoma of cervix — Duration 2 mos

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rayner Browne M. D.

Address 1500 E. Madison St Date signed 1/30

Rayner Browne X

625319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. 625319

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1608 Mt. Royal ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 Mt Royal ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James F. Oliver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married,~~ widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or~~ wife: Alice Oliver

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) July 1st 1870

8. AGE: Years 74 | Months 6 | Days 29 | If less than one day: hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Carpenter

FATHER
12. Name: William H. Oliver
13. Birthplace: Balto Md.

MOTHER
14. Maiden Name: Olivia Beecham
15. Birthplace: Balto Md.

16 (a) Informant: Mrs Helen Oliver
(b) Address: 1608 Mt. Royal ave

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 3/2/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~: London Park
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 845 E. Fayette St.

19 (a) JAN 31 1945 (Date rec'd by registrar) (b) ~~Filed~~ Entered by: Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30th 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1944 to Jan 30th 1945; and that I last saw ~~him~~ alive on Jan 29th 1945.

Immediate cause of death: Pulmonary Carcinoma — Duration 6 mo.

Due to: August 1944

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H. A. Fillial, M. D.

Address 416 N Fulton Ave Date signed 1/31/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

125320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 125320

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2517 Emerson st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V°
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2517 Emerson st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John W. Patterson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Ollie Patterson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 10th 1873

8. AGE: Years	Months	Days	If less than one day
71	2	20	hr. min.

9. Birthplace Reisterstown
(town, county, and state)
10. Usual Occupation Retired
11. Industry or business Farmer

FATHER
12. Name Unknown Patterson
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Aaron T. Patterson
(b) Address 2517 Emerson st

17 (a) Burial (b) Date thereof 2-2-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30th 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1945, to Jan 30 1945, and that I last saw h[illegible] alive on Jan 24 1945.

Immediate cause of death	Duration
Hypertensive Cardio-Vascular Disease	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Asher Pikesley
Address 2302 Edmondson Ave Date signed M. 1/30/45 D.

625321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 625321

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2121 N. Saratoga St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 N. Saratoga St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Schmidt

3 (b) If veteran, name war: N
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1853

8. AGE	Years	Months	Days	If less than one day
about	92			hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Hoffzing
15. Birthplace Germany

16 (a) Informant Wm. Wolf
(b) Address 2121 N. Saratoga St

17 (a) Burial (b) Date thereof 1/31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudenslager
Location Baltimore Md

18 (a) Funeral director Wilson Wolf Inc
(b) Address 1210 E. Fort Ave

19 (a) JAN 31 1945 (b) Wilson, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1945 to Jan 29 1945, and that I last saw h[illegible] alive on Jan 26 1945.

Immediate cause of death	Duration
Myocardial insufficiency	
Due to	
Due to	
Other Conditions Arteriosclerosis, Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature Walter A. Schmidt
Address 1337 S. Clarke St (Date signed) 1/31/45

625322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

✓ 625322 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Denison street
(c) Hospital or institution:
Crawford Rest Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ----
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 John street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM FRANCIS COSTELLO

3 (b) If veteran, name war: ---

3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Widowed

6 (b) Name of husband or wife Katherine T. Costello
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1868

8. AGE: Years	Months	Days	If less than one day
76	5	15	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Patrick S. Costello
13. Birthplace Ireland

MOTHER
14. Maiden Name Hannah Higgins
15. Birthplace England

16 (a) Informant Mrs. Loretta Hartman
(b) Address 1518 John street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans Son Inc
(b) Address 118 N. Mt. Royal Ave

19 (a) JAN 31 1945 (Date rec'd by registrar) (b) per for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 1945, at 1 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/18 1945 to 1/27 1945, and that I last saw him alive on 1/27 1945.

Immediate cause of death: Pulmonary edema — Duration: 2 hrs.

Due to: Arteriosclerotic heart disease — Duration: ?

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert A. Reiter M. D.
Address 3408 Windsor Ave Date signed 1/29/45.

VS 150

625323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 625323

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2231 N. Calvert street
(c) Hospital or institution: 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) *****
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2231 N. Calvert street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MABEL L. BLESSING

3 (b) If veteran, name war: -----
3 (c) Social Security Account No. ---

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: -----
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1883

8. AGE: Years 61 | Months 4 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired- School Teacher

11. Industry or business

FATHER
12. Name Daniel G. Blessing
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary
15. Birthplace

16 (a) Informant Mrs. John Power
(b) Address 2231 N. Calvert street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Clay F. Evans Sons
(b) Address 118 W. Mt. Royal Ave

19 (a) Filed by registrar JAN 31 1945 Howard Sta Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29 1945, at 2P, M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/14 1944, to 1/29 1945, and that I last saw h[illegible] alive on 1/29 1945

Immediate cause of death: Cardio-Renal Hypertension — Duration 2yrs.
Due to: Aortic Regurg. Arteriosclerosis
Due to: ---
Other Conditions: ---

(Include pregnancy within 3 months of death)
Date of operation: ---
Major findings of operation: ---
of autopsy: ---

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Otto T. Mason M. D.
Address 804 Cathedral St. Date signed 1/30/45

X

G65324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. G65324

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Williams & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 E. Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Mary Hartnett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 23-1862

8. AGE: Years	Months	Days	If less than one day
82	1	7	hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation AT HOME

11. Industry or business

FATHER
12. Name John (Dec.)
13. Birthplace Ireland.

MOTHER
14. Maiden Name Mary Howard (Dec.)
15. Birthplace Ireland.

16 (a) Informant Miss M. Madigan
(b) Address 705 E. Chase St.

17 (a) Burial (b) Date thereof 2/3/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas J. Evans' Son Inc
(b) Address 118 W. Mt. Royal Ave.

19 (a) JAN 31 1945 Huntington, West Virginia
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30 1945, at 9 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/19 1945, to 1/30 1945, and that I last saw h[illegible] alive on 1/30 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Peritonitis	
Due to Strangulated femoral hernia	
Other Conditions Degenerative C-V disease	

(Include pregnancy within 3 months of death)

Date of operation 1-22-45

Major findings of operation: Strangulated femoral hernia

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard W Steer M. D.
Address St Agnes Hosp Date signed 1-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G63325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

Registered No. G63325

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 CAROLINE ST.
(c) Hospital or institution: ST JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3114 HARFORD ROAD (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. CATHERINE HAYDEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife DR. BENJ. HAYDEN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/1/76

8. AGE: Years 68 | Months 7 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name THEODORE KING
13. Birthplace PHILA. PA

MOTHER
14. Maiden Name CLARA BRAUER
15. Birthplace BALTO.

16 (a) Informant BENJAMIN HAYDEN
(b) Address 229 SUDBROOK AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-45 (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE
Location PIKESVILLE

18 (a) Funeral director CHAS. F. EVANS & SON
(b) Address 118 W MT. ROYAL AVE.

19 (a) JAN 31 1945 (Date rec'd by registrar) Clarence Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 30 1945 at 1.45 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1944 to 1/30 1945, and that I last saw HER alive on 1/30 1945.

Immediate cause of death CARDIAC & RESPIRATORY FAILURE — Duration

Due to CORONARY OCCLUSION

Due to

Other Conditions ARTERIOSCLEROSIS

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry J. Houska M. D.
Address 22 St Joseph's Hosp. Date signed 1/30/45

VS 150

~~326~~ G25326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G25326

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4404 Chatham Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4404 Chatham Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN W. CROWLEY, SR.

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Emma V. Crowley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/1871

8. AGE: Years 73 | Months 11 | Days 6 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Westinghouse Elec & Mfg Co

FATHER
12. Name William J. Crowley
13. Birthplace England

MOTHER
14. Maiden Name Charlotte A. Smyth
15. Birthplace England

16 (a) Informant Mrs. Mildred C. McCaghey
(b) Address 4404 Chatham Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (c) FEB 1 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28, 1945, at 9:45PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1944 to Jan 28 1945 and that I last saw him alive on Jan. 28 1945

Immediate cause of death
1 Arteriosclerotic Heart Disease
Due to
Due to
Other Conditions - Cerebrosis of liver
(Include pregnancy within 3 months of death)
Date of operation - None
Major findings of operation:
of autopsy: No

Duration
- 5yrs.
5yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 4108 Liberty Hts Date signed 1/31/45

9301

G25327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V G25327 / 3 / B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2604 Francis St.
(c) Hospital or institution: 12-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2714 Parkwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET LORETTA KAVANAUGH

3 (b) If veteran, name war: -

3 (c) Social Security Account No. 212-14-1525

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife: Edward T. Kavanaugh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/4/1901

8. AGE: Years	Months	Days	If less than one day
43	10	25	hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation: Waitress
11. Industry or business: Up Town Night Club

FATHER
12. Name: Frank J. Winter
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Margaret L. Fuller
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Joseph Crouse
(b) Address: 2604 Frances St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) FEB 1 1945 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 29, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 1945, to Jan 29 1945, and that I last saw h[illegible] alive on Jan 29 1945.

Immediate cause of death	Duration
Coronary Thrombosis	[illegible]
Due to Mitral Insufficiency	1 year
Due to Chronic Parenchymatous Nephritis	1 year
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Smith M. D.
Address 4509 Roland Ave. Date signed Jan 30

VS 150

625328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

625328 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 South Green
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 South Green
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John G. Jamison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch 15 1900

8. AGE: Years	Months	Days	If less than one day
44	10	13	hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation laborer

11. Industry or business Davidson Paint Co

FATHER
12. Name Bernard Jamison
13. Birthplace Va

MOTHER
14. Maiden Name Sarah E. Chambers
15. Birthplace Va

16 (a) Informant Alberta Jamison
(b) Address 605 S. Green

17 (a) Burial (b) Date thereof Jan 31 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director James A Stamps
(b) Address 1742 Wolfe St

19 (a) JAN 31 1945
(Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 3270

20. DATE OF DEATH Jan 28 1945; at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1944 to 1/28 1945.
and that I last saw h alive on 1/28 1945.

Immediate cause of death Carcinoma of Colon.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hunt Townsend M. D.
Address Y Date signed 1/30/45

X

G25329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G25329 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3514 Roland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3514 Roland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Smith

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Annie V. Smith

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Oct 6 - 1873

8. AGE: Years	Months	Days	If less than one day
71	3	21	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Cotton Carder

11. Industry or business Textile

FATHER 12. Name Joseph Smith

13. Birthplace Md

MOTHER 14. Maiden Name Mary A. Price

15. Birthplace Md

16 (a) Informant Annie V. Smith

(b) Address 3514 Roland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31 1945 (month) (day) (year)

(c) Cemetery or crematory Jessop Cem

Location Rockville Md

18 (a) Funeral director Raff & B.M. Walker

(b) Address Raff & Strickers

19 (a) Jan 31 1945 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27th 1945 at 10 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1945, to Jan 27 1945, and that I last saw him alive on Jan 26 1945.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Arteriosclerotic CVD	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Flamm M. D.

Address 3711 Falls Rd Date signed 1-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 The Alameda
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-4
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 The Alameda (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie J. Williams

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ezekiel A. Williams

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) March 14 1878

8. AGE: Years 66 | Months 10 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or Business

FATHER 12. Name John Gregory
13. Birthplace Md

MOTHER 14. Maiden Name Sarah F. Corkran
15. Birthplace Md

16 (a) Informant Ezekiel A. Williams
(b) Address 1807 The Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1-1945 (month) (day) (year)
(c) Cemetery or crematory Western
Location City

18 (a) Funeral director Raff & B.M. Walter
(b) Address 1417 Stricker Sts

19 (a) [illegible] (b) Registrar

Registered Feb 1 1945

Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29th 1945, at 9 yr A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1944 to Jan 29 1945; and that I last saw her alive on Jan 29 1945.

Immediate cause of death	Duration
Cerebral Thrombosis	2 hrs.
Due to Arteriosclerosis	Indef.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. E. K. Campbell M.D.

Address 1644 Hanover St Date signed 1/30/45

X

G65331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G65331

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Laynes Lane & Dukeland St
(c) Hospital or institution: West Balto. Gen. Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 322 S Parrish St #2 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lydia M. Sparenberg

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	White	MARRIED

6 (b) Name of husband or wife Joseph H

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) March 14 - 1886

8. AGE: Years	Months	Days	If less than one day
67	10	15	hr. min.

9. Birthplace BALTIMORE Md (Town, county, and state)

10. Usual Occupation House WIFE

11. Industry or business

FATHER
12. Name John German
13. Birthplace Md

MOTHER
14. Maiden Name Lydia Smith
15. Birthplace Md

16 (a) Informant Joseph H. SPARENBERG
(b) Address 322 S. PARRISH St 2S

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB 1-1945 (month) (day) (year)
(c) Cemetery or crematory WESTERN City
Location Bolt & B.M. Walter

18 (a) Funeral director
(b) Address PARK & Stricker Sts

19 (a) JAN 31 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/29 1945, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/6 1945, to 1/29 1945, and that I last saw h alive on 1/29 1945.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Generalized Arteriosclerosis	
Due to HCVD	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving J. Taylor
Address WBGH Date signed 1/30/45 D.

93D

623332 X V 623332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 623332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 93 Fenway North apt. 8
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Pott 3-16870

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-15-45

8. AGE: Years | Months | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name William Pott
13. Birthplace Md

MOTHER 14. Maiden Name Evelyn Welch
15. Birthplace Md

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JAN 27 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 31 1945 (Date rec'd by registrar) (Signature) Hamilton for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-25- 1945, at 5 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1945 to 1-26- 1945, and that I last saw h.[illegible] alive on 1-26- 1945

Immediate cause of death Premature birth —
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allen C. Wooden M. D.
Address W. B. G. H. Date signed 1-26-45

VS 160

2481 X

G25333

AB-91580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G25333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 47
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 West Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Lowry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13-1882

8. AGE: Years	Months	Days	If less than one day
62	7	15	hr. min.

9. Birthplace Missouri
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alfred Lowry (D)
13. Birthplace ?

MOTHER
14. Maiden Name Eliza Lankford
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 1/31/45
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City, Md.

18 (a) Funeral director Fleury & Fleming
(b) Address 1426 Light St

19 (a) 1 1945 (b) Huntington Williams M.D.
(Date received by registrar) (Registrar)

VS-150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Jan. 28- 1945, at 10.15 M

21. I certify that death occurred on the date above stated: that I attended deceased from 1-13- 1945 to 1-28- 1945 and that I last saw h im alive on 1-28- 1945

Immediate cause of death Coronary occlusion — Duration 7

Due to

Due to

Other Conditions Carcinoma of Liver Bronchectasis — Duration ? ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cancer

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Woodward M. D.

Address Baltimore City Hospitals Date signed 1-30-45

942

625334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

115 B

625334 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2429 N. Howard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lela Harriel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joe - (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-30-94

8. AGE: Years 50 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Ga. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER — 12. Name Joe Rucker
13. Birthplace Ga.

MOTHER — 14. Maiden Name Frances Higginith
15. Birthplace Ga.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 1 45 (month) (day) (year)
(c) Cemetery or crematory
Location Edberton Georgia

18 (a) Funeral director Mrs. Robert A. Elliott
(b) Address 1129 N. Carrollton Ave

19 (a) (Date received by registrar) JAN 31 1945 (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29 1945 at 6.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1945 to Jan. 29 1945 and that I last saw her alive on Jan. 29 1945.

Immediate cause of death	Duration
Ruptured spleen	
Due to Septic infarct	
Beta hemolytic streptococcus	
Due to Empyema, streptococcal	
Other Conditions Hypertensive cardiovascular disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Ruptured spleen - empyema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus
Address Johns Hopkins Hosp. Date signed 1/30/45

625335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 625335

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton and
(c) Hospital or institution: Jenkins Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. Co. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7614 Olita, Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary A. Schuldenberg
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W.
6 (a) Single, married, widowed or divorced.
6 (b) Name of husband ~~or wife~~ Fred.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 27-1889
8. AGE: Years 55 | Months 2 | Days 3 | If less than one day hr. min.
9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name Herman Eckmeyer
13. Birthplace Balto. Co. Md.
MOTHER 14. Maiden Name Rose Ginhand
15. Birthplace Balto. Co. Md.
16 (a) Informant Miss Katherine Eckmeyer
(b) Address 7614 Philadelphia Rd.
17 (a) Burial (b) Date thereof Feb. 3-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.
18 (a) Funeral director John E. Ingram
(b) Address 3000 E. Balto. St.
19 (a) JAN 31 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30 1945 at 9:10 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1944 to 1/30 1945 and that I last saw h. alive on 1/30 1945
Immediate cause of death Respiratory failure
Due to Probable Pneumonia
Due to Hypertensive Cardio-Vascular Disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature William J. Byron M. D.
Address St. Agnes Hosp. Date signed 1/30/45

G25336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

G25336
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution:
Church Home 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 218 North Castle
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME John F. Mauer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs. Elizabeth Mauer
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) June 27 - 1888

8. AGE: Years	Months	Days	If less than one day
56	7	2	..... hr. ..... min.

9. Birthplace — (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name — Dont Know
13. Birthplace — Md

MOTHER
14. Maiden Name — Dont Know
15. Birthplace — Md

16 (a) Informant Wife Elizabeth Mauer
(b) Address 218 N. Castle St.

17 (a) Burial (b) Date thereof 2/2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2004 E. Oliver St

19 (a) [illegible] Huntington for Williams
(Filed by Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1945, at 5 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29 1945 to 1-29 1945 and that I last saw h Um alive on 1-29 1945

Immediate cause of death Bronchial asthma — Duration 5 mos

Due to ?

Due to —

Other Conditions Hypertensive vascular disease — Duration 2 yrs
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Marvin W. Davis M. D.
Address Church Home Date signed 1-29-45

X

625337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 D

625337 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 Riggs ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Riggs ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Bell Dumas

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace Starville, Ga. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Rean Dumas
13. Birthplace Ga

MOTHER
14. Maiden Name Evelyn Mullen
15. Birthplace Ga

16 (a) Informant William Geary
(b) Address 1414 Riggs ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/45 (month) (day) (year)
(c) Cemetery or crematory West View
Location Atlanta Ga.

18 (a) Funeral director Chas. H. Alexander
(b) Address 927 N. Mount St.

19 (a) JAN 31 1945 (Date filed by Registrar) Hunter for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1945, at 8 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 1944 to 1/30 1945, and that I last saw her alive on Jan 27 1945.

Immediate cause of death: Vascular Heart Disease — Duration: —
Due to: Hypertension — Duration: 2 yrs
Due to: — Duration: —
Other Conditions — Duration: —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Douglas E Pepperd
Address 1414 Riggs Date signed 1/30/45 M. D.

VS 3

G25338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G25338

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use typewriter if possible. If not, write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: So. Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Curtis Bay (If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 Church St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3 (a) FULL NAME Joseph C. Read (Joseph Charles Edgar Read)

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 216-07-9044

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Marion Read
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7-26-72

8. AGE: Years 72 | Months 6 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business U. S. Chemical Co.

FATHER 12. Name Elois A. Read
13. Birthplace Indiana

MOTHER 14. Maiden Name Rebecca Childs
15. Birthplace Maryland

16 (a) Informant Marion Read
(b) Address 1405 Church St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 31 1945
(Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29- 1945, at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27- 1944, to 1-29- 1945, and that I last saw him alive on 1-29- 1945

Immediate cause of death	Duration
Hypostatic pneumonia	5 days
Due to cerebral hemorrhage	1 mo
Due to	
Other Conditions hemiplegia, Rt.	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M.
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Charles R. Markwardt M. D.
Address 123 Light St. Date signed.....

G25339

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G25339

CERTIFICATE OF DEATH 54B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 Sudbrook Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul Frederick Cullison III.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 1936

8. AGE: Years	Months	Days	If less than one day
8	8	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Paul Frederick Cullison, Jr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret L. Miller
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Paul Frederick Cullison, Jr.
(b) Address 515 Sudbrook Lane, Pikesville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/45 (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

JAN 31 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30 1945, at 1:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27 1945 to 1/30 1945 and that I last saw him alive on 1/30 1945.

Immediate cause of death Respiratory failure — Duration

Due to Medullary compression — Duration

Due to Intracranial tumor — Duration over

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1/29/44

Major findings of operation: Cystic change in right frontal & parietal lobes of brain - right frontal bone

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Helen A. Home M. D.
Address Univ. Hospital Date signed 1/30/45

VS 150

X

625340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 625340

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Sparrows Point, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 811 C. Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GEORGE VENABLE GLADDEN

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 213-10-4087

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Martha Ellen Green
6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) June 1, 1878

8. AGE: Years	Months	Days	If less than one day
66	7	28	hr. min.

9. Birthplace Chance, Somerset Co. Md. (Town, county, and state)
10. Usual Occupation Beth. Shipbuilding Co.
11. Industry or business Retired 8 Mo.

FATHER
12. Name George Wm. Gladden
13. Birthplace Somerset Co. Md.

MOTHER
14. Maiden Name Harriett parks
15. Birthplace Somerset Co. Md

16 (a) Informant Mrs. Margaret F. Gladden
(b) Address 811 C. Street. Sp. Pt. Md

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 2-1-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address worth Ave. & Broadway

JAN 31 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/29 1945; at 10 57 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1945 to 1/29 1945; and that I last saw him alive on 1/29 1945

Immediate cause of death Cardiac failure

Due to Coronary occlusion

Due to Coronary arterio-sclerotic H. dis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Altman M. D.
Address Sinai Hosp Date signed 1/31/45

625341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

625341 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3612 Keene Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 4
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3612 Keene Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice A. Bell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Harry C. Bell
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) June 14th 1864

8. AGE: Years	Months	Days	If less than one day
80	7	15	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation home work
11. Industry or business at home

FATHER
12. Name Timothy Holland
13. Birthplace Ireland

MOTHER
14. Maiden Name Alice Hayes
15. Birthplace Ireland

16 (a) Informant Mrs Harry C. Bell
(b) Address 3612 Keene Ave "

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location 3801 Hedgelea Ave

18 (a) Funeral director John F. Cowan & Son
(b) Address 901-03 Fallsway

19 (b) JAN 31 1945 (Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29th 1945, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1944 to Jan 29 1945, and that I last saw h[illegible] alive on Jan 29 1945.

Immediate cause of death Chronic Cardio renal dis — Duration

Due to —

Due to —

Other Conditions Carcinoma Liver

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Grant D. Rabun
Address 1736 Pag St Pk Date signed 1/31/45

M. D.

Huntington Williams, M.D.

1312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G65342
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hosp. 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1434 N. Patterson Park ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John Nugent

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16 1895

8. AGE: Years	Months	Days	If less than one day
49	7	13	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Pipe fitter

11. Industry or business Beth Steel Co.

FATHER
12. Name Thomas J Nugent
13. Birthplace New Orleans

MOTHER
14. Maiden Name Nora Winters
15. Birthplace Baltimore Md

16 (a) Informant Mrs Nora Nugent
(b) Address 2812 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/45 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem.
Location Taylor Ave, Parkwood, Md

18 (a) Funeral director John J Cowden & Son
(b) Address 2003 Gallows St

19 (a) JAN 31 1945 (Date rec'd by registrar) (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29, 1945, at 12 30 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/21/45 at 4/1 M.
(b) Where did injury occur? Pier #6 Pratt St
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell from scaffold

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Jan 30 1945

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied—correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 343

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hosp. 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 830 W. Lombard St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME ~~Victoria~~ ANNIE ~~Patterson~~ CATTERTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Makeman — 1874

8. AGE: Years 71 | Months | Days | If less than one day hr. min. 70

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Home work

11. Industry or business at home

FATHER
12. Name.....
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name.....
15. Birthplace Baltimore Md.

16 (a) Informant.....
(b) Address.....

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/45 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location 3801 Field Ave

18 (a) Funeral director John J Gorman & Son
(b) Address 1003 Hollins St

19 (a) JAN 31 1945 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1945 at M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cancer of Breast

.....

.....

Due to.....

.....

Other Conditions.....

.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Jan 28 1945

(over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Md. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4222 Frederick Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Eckhardt

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1865

8. AGE: Years	Months	Days	If less than one day
79	8	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Martin Connelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Dever
15. Birthplace Ireland

16 (a) Informant Mr. Milton B. Eckhardt
(b) Address 4222 Fred Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location End of E. North Ave.
18 (a) Funeral director John F. Cowan & Son
(b) Address 900 N. Gilmor St.
19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

JAN 31 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30 1945, at 7:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11 1945 to Jan. 30 1945, and that I last saw h.CY alive on Jan. 30 1945

Immediate cause of death Bronchopneumonia, on 12th day after operation for release of

Due to	adhesions & drainage of gall-bladder because of	
Due to	Carcinoma of the gall bladder.	
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation Jan. 18, 1945
Major findings of operation: Carcinoma of Gall Bladder & adhesions
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. W. Traynor M. D.
Address Md. Gen'l Hosp. Date signed 1/30/45

X

625345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181B

625345 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W. Rogers ave.
(c) Hospital or institution: Home for the Aged of the Methodist Church
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate Meneron

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1861

8. AGE: Years	Months	Days	If less than one day
83	11	6	hr. min.

9. Birthplace Baltimore Co., Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Edward Meneron
13. Birthplace Md.

MOTHER
14. Maiden Name Katherine Hook
15. Birthplace Md.

16 (a) Informant Miss Miriam A. Coates
(b) Address 2211 W. Rogers ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Springfield Cemetery
Location Lyndenville, Md.

18 (a) Funeral director C. Harry Ewen
(b) Address Lyndenville, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 31 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1945 at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to Jan 29, 1945, and that I last saw h.. alive on Jan 29 1945

Immediate cause of death Uremia — Duration 10 days

Due to Chronic Nephritis — Duration 5 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur J Davis M. D.
Address 800 N 3rd Date signed 1-30-45

G25346

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G25346
Registered No.

CERTIFICATE OF DEATH 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Physicians: please write the correct age is especially important. Physicians: please write to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pimlico & Green Sts
(c) Hospital or institution: Univ Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Randallstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Julia Miller

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife John B Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1865

8. AGE: Years	Months	Days	If less than one day
79	8	6	hr. min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Daniel McSweeney
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Cherry
15. Birthplace England

16 (a) Informant J. R. Davis
(b) Address 2413 Fairway Randallstown

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto. Md.

18 (a) Funeral director C. Harry Klein
(b) Address Catonsville, Md.

19 (a) FEB 21 1945 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30 1945 at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16 1945 to 1-30 1945 and that I last saw her alive on 1-30 1945

Immediate cause of death renal failure — Duration

Due to stasis

Due to

Other Conditions broken hip
(Include pregnancy within 3 months of death)

Date of operation 1-30-45

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 1-16-45
(c) Where did injury occur? Randallstown Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? —
(Specify type of place)
(e) Means of injury slipped and fell on floor

23. Signature E. [illegible] M. D.
Address Univ Hospital Date signed 1-30-45

VS 150

Huntington Williams, M.D.
Approved by Howard J. Markell, M.D. X

467847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 625347

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 Lexington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William James Thorpe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-13-44

8. AGE: Years	Months	Days	If less than one day
	10	16	hr. min.

9. Birthplace md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Willie Thorpe.
13. Birthplace [redacted]. N.C.

MOTHER
14. Maiden Name Lucille Daye
15. Birthplace Va

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Jan 31, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 3228 Schroeder St.

19 JAN 31 1945 Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan-29- 1945 at 4.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-24 1945 to Jan-29 1945. and that I last saw him alive on Jan 29- 1945.

Immediate cause of death: Pneumonia Bronchiolitis — Duration: 12 days I 12 days

Due to

Due to

Other Conditions? Intranuclear pathology (Virus)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Russell Whitehouse M. D.
Address Johns Hopkins Hospital Date signed 1/29/45

VS 150

Medesky

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G25348

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Your correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto Md
(b) Street address 216 Sharp St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State — (b) County
(c) City or town Balto Co Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 216 Sharp St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country Russia

3 (a) FULL NAME Martin Medesky

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Magdelena Medesky
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Unknown
8. AGE: Years: About 68 | Months | Days | If less than one day: hr. min.
9. Birthplace Liagonka Volyn Russia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Joseph Medesky
13. Birthplace Liagonka Volyn Russia

MOTHER
14. Maiden Name Marie (Unknown)
15. Birthplace Liagonka Volyn Russia

16 (a) Informant Ben Frank Rachek
(b) Address 216 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1 - 45 (month) (day) (year)
(c) Cemetery or crematory St Andrews Pro Cath Cem
Location Ar A. Co Md

18 (a) Funeral director Haslin Bowles Bradley Inc
(b) Address 1922 W North Ave at Monroe

19 JAN 31 1945 (b) Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29, 1945, at 11.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9, 1945, to Jan 29, 1945, and that I last saw him alive on Jan 29, 1945

Immediate cause of death: Carcinoma of stomach

	Duration
Due to: with metastases	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Sidney L. Levy M. D.
Address 2322 Fontaw Pkwy Date signed 1/30/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G25349 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 304 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lottie S Lewrod

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Lawrence S Lewrod

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1911

8. AGE: Years 33 | Months 2 | Days 28 | If less than one day: hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Knight
13. Birthplace North Carolina

MOTHER
14. Maiden Name Florence Clover
15. Birthplace North Carolina

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31st 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location W. A. Cor Md.

18 (a) Funeral director Robson Virginia K. Knight
(b) Address 7 Tallapoosa St

19 (a) JAN 31 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1945 at 11.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 17 1945 to Jan. 28 1945 and that I last saw her alive on Jan 28 1945.

Immediate cause of death	Duration
Uremia	
Due to Hypertensive cardiovascular disease	
Due to Arteriosclerotic nephrosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Arteriosclerotic kidneys

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Hattem, M. D.
Address Johns Hopkins Hosp Date signed 1/29/45

VS 150

625350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

625350

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address RAYNER & OAKELAND

(c) Hospital or institution: WEST BALT. GEN. HOSP.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2305 W. Lexington St. (If rural give location)

(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME EMIL KLINGER

3 (b) If veteran, name war Spanish & World War I

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 17, 1859

8. AGE: Years 85 Months 10 Days 12 If less than one day hr. min.

9. Birthplace Switzerland (town, county, and state)

10. Usual Occupation Soldier

11. Industry or business Army

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs Smith

(b) Address 2305 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/45 (month) (day) (year)

(c) Cemetery or crematory Baltimore National

Location Pulaski Rd

18 (a) Funeral director Thos F Kenny

(b) Address Holbrook & Belmont

19 (a) (Date received by Registrar) (b) JAN 31 1945 Registrar

VS 116

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 29 1945 at 7:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/22 1945 to 1/29 1945 and that I last saw h. alive on 1/28 1945.

Immediate cause of death UREMIA

Due to PERI-URETHRAL INDURATION

Due to

Other Conditions 1) AORTIC INSUFFICIENCY 2) Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature G. M. Ehrenfeld M. D.

Address West Balt. G. H. Date signed 1/29

625351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

625351
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1020 N. Central Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 N. Central Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad J. Busch

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1871

8. AGE: Years 73 | Months 9 | Days 28 | If less than one day ### min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Lawrence Busch
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Koehler
15. Birthplace Germany

16 (a) Informant Miss Mollie Busch
(b) Address 1020 N. Central Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 JAN 31 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29, 1945, at 11A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944, to Jan 29 1945, and that I last saw h alive on Jan 27 1945.

	Duration
Immediate cause of death: Benign Prostatic Hypertrophy	1 year
Due to: Cystitis	4 mos
Due to: Carcinoma Rectum	7 days
Other Conditions: Uremia	3 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alex Attlensloch, M. D.
Address 4603 Park Heights Ave Date signed 1/30/45

625352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625352
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1625 N.Spring Street
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 N.Spring Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Connor

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John H.Connor
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) March 9th, 1888

8. AGE: Years 56 | Months 10 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Adam Popp
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Weigel
15. Birthplace Germany

16 (a) Informant John H.Connor
(b) Address 1625 N.Spring Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb.1,1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E.North Avenue

18 (a) Funeral director George J.Ruth,Inc.
(b) Address 1735 Harford Avenue

19 (a) JAN 31 1945 (Date rec'd by registrar) (b) Huntington Wallace, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29, 19 45 at 8 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1939 to Jan. 29 1945, and that I last saw her alive on Jan. 29 1945

Immediate cause of death	Duration
Arteriosclerotic & V disease	1½ yrs
Cardiac decompensation	1939
Coronary occlusion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Brengar M. D.
Address 1402 E. Lanvale Date signed 1-27-45

625353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64

625353 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 143 W. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 143 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wheland Chatard

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: FEMALE
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12-19-44
8. AGE: Years | Months: 1 | Days: 12 | If less than one day: hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER 12. Name FERDINAND E. CHATARD
FATHER 13. Birthplace Baltimore, Md.
MOTHER 14. Maiden Name Constance Lynn Chatard
MOTHER 15. Birthplace —

16 (a) Informant Dr. Jas R. Chatard
(b) Address 1300 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director Hunneman & Son
(b) Address 605 N. Calvert St.

19 (a) JAN 31 1945 (Date received by registrar) Washington Williams, M.R. Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-31 1945, at 9 60 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw her alive on 1-30 1945.

Immediate cause of death	Duration
Not known	
Due to ?? Status thymolymphaticus	
Due to	
~~Other Conditions~~ Reported to Medical Examiner (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: To be reported later.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas R. Chatard M. D.
Address 1300 N. Calvert St. Date signed Jan 31/45

approved by Thomas J. Mullen M.E.

625354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93a

Registered No. 625354

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the ... the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1602 Spray Ct.
(c) Hospital or institution:
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Spray Court (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Wiggins

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife: Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/1883

8. AGE: Years	Months	Days	If less than one day: hr.	min.
61	1	4		

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Robinson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Fischer
15. Birthplace ? Md

16 (a) Informant Alice Wiggins (Daug).
(b) Address 1602 Spray Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) FEB 2 1945 (Date received by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/29/45 19 , at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1·28 1945 to 1·29 1945; and that I last saw h[illegible] alive on 1·29 1945.

Immediate cause of death: Acute myocarditis
Due to: Central arteriosclerosis
Due to: Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
1 day
2 days
1 wk

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. L. Berry M. D.
Address 1420 E. Chase Date signed 1·31·45

Colored 65365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 188 Colored 65365

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1149 N. Mount St.
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME James Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife.....

6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1944

8. AGE: Years | Months: 3 | Days: 15 | If less than one day ... hr. ... min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Melvin Smith
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Alice Hill
15. Birthplace Balto., Md.

16 (a) Informant Alice Smith (mother)
(b) Address 1142 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Balto Md.

18 (a) Funeral director Chas. Glover
(b) Address 512 N. Carrollton Ave

19 (a) JAN 31 1945 (b) Huntington Avenue, Md. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30, 1945, at 1:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Interstitial pneumonia

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Scarborough M.D.
Medical Examiner.
Date signed Jan 30 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625356 / 107 625356 Registered No.

625356

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 W. West Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Brunson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/3/44

8. AGE: Years | Months: 8 | Days: 27 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lewis Brunson
13. Birthplace S. C

MOTHER
14. Maiden Name Mildred Tuell
15. Birthplace Va

16 (a) Informant Mildred Brunson
(b) Address 508 W West

17 (a) Burial (b) Date thereof 2/1/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location a. a. Co. Md

18 (a) Funeral director Isaiah L. Brunson
(b) Address 108 W Montgomery St

19 (a) JAN 31 1945 (b)
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1945 at 3:15 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mulleen M.D.
Medical Examiner.
Date signed 1-30-45

625357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625357 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution St Agnes Hospital ward
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 E. 41st St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FLORINE G REMINGTON Mrs. Florence Remington
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. M.
6 (b) Name of husband or wife Stanley
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 2, 1875
8. AGE: Years 69 | Months 6 | Days 27 | If less than one day hr. min.
9. Birthplace Chambersburg Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at Home

FATHER
12. Name Aloysius Cook
13. Birthplace unknown

MOTHER
14. Maiden Name Harvey
15. Birthplace unknown

16 (a) Informant Mr. Stanley G Remington
(b) Address 609 E. 41st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. City.

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 31 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/29/ 1945 at 9:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 1945 to 1/29 1945, and that I last saw h. alive on 1/29 1945.

Immediate cause of death Respiratory failure — Duration
Due to Cerebral Hemorrhage
Due to Hypertensive Cardio-Vascular Disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William J. Bryson M.D.
Address St. Agnes Hosp Date signed 1/29/45

Huntington Williams, M.D.

G25358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G25358

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) Inste.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore City

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 106 N. University Parkway

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Ethel D. May (ETHEL DEAN MAY)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Charles M. May

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Jan. 7 1890

8. AGE: Years 55 Months 0 Days 22 If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Housf.

11. Industry or business

FATHER 12. Name Dr. Jno. M. Dean

13. Birthplace Va.

MOTHER 14. Maiden Name Annie W. Fillman

15. Birthplace Md.

16 (a) Informant Mr. Chas. M. May (husband)

(b) Address 106 W University Pky

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-45 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Baltimore

18 (a) Funeral director Sherwood Memorial Co.

(b) Address 1054 Madison Ave.

19. JAN 31 1945 (Date received by Registrar) (b) Hunting for Williams MR (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29th 1945, at 7 40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7 1944 to Jan. 29 1945 and that I last saw h[illegible] alive on Jan. 27 1945.

	Duration
Immediate cause of death Cardiac Failure	
Due to Degenerative myocarditis	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature I. D. Paul Lampas, M.D.

Address Mercy Hospital Date signed 1/29/45

VS 150

X

G25359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B O E

G25359 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Park & Mulberry Sts

(c) Hospital or institution: Capital Hotel

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 year

(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED

(a) State Md (b) County Baltotaty

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Park & Mulberry Sts (If rural-give location)

(e) Citizen of foreign country? — ? — (Yes or No)

If yes, name country

3 (a) FULL NAME Hom Foo (Chinese)

3 (b) If veteran, name war — ? —

3 (c) Social Security Account No. — ? —

4. Sex: Male

5. Color or race: Yellow

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Could not ascertain

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) About 1899

8. AGE: Years: About 46 | Months: — | Days: — | If less than one day: hr. min.

9. Birthplace: Could not ascertain (Town, county, and state)

10. Usual Occupation: Laundry

11. Industry or business: —

FATHER

12. Name: Could not ascertain

13. Birthplace: " " " " "

MOTHER

14. Maiden Name: Could not ascertain

15. Birthplace: " " " " "

16 (a) Informant: Hom Sing - (Cousin)

(b) Address: 316 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-45 (month) (day) (year)

(c) Cemetery or crematory: Lorraine

Location: Woodlawn

18 (a) Funeral director: Stewart & Marino Co

(b) Address: 108 W Monk Ave

19 (a) JAN 31 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 30 1945, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1945, to 1/30 1945, and that I last saw h— alive on 1/27 1945

Immediate cause of death: Mental Regurgitation - Decompensated

Due to

Due to

Other Conditions: Syphilis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 6 hrs ?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M.D.

Address 901 Eutaw St Date signed 1/31/45

VS 150

625360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

625360
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 34 N. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Allen.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-10-1902.

8. AGE: Years	Months	Days	If less than one day
42.	10	19	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Crawford Allen
13. Birthplace Va.

MOTHER
14. Maiden Name Lizzie Allen
15. Birthplace Va

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2/2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County

18 (a) Funeral director Lay [illegible] Saunders
(b) Address 1412 E. [illegible]

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 1[illegible] JAN 31 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29 1945, at 5.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-28 1945 to Jan-29 1945, and that I last saw him alive on Jan 29 1945.

Immediate cause of death	Duration
Acute bacterial endocarditis	
Due to Abscess of myocardium	
Due to	
Other Conditions Lobar pneumonia RML	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Acute bact. Endocarditis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Albert A. Kattus M. D.
Address Johns Hopkins Hosp. Date signed 1/30/45

910

625361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625361 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4948 Edgemere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SOLOMON RUDNITSKY

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. married
6 (b) Name of husband or wife Ida Rudnitsky
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1880
8. AGE: Years 65 | Months | Days | If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Louis –
13. Birthplace Russia

MOTHER
14. Maiden Name Tauba –
15. Birthplace Russia

16 (a) Informant Ida Rudnitsky
(b) Address 4948 Edgemere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-45 (month) (day) (year)
(c) Cemetery or crematory North Pt. Rd
Location O'Donnel St
18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto. St
19 (a) JAN 31 1945 (Date received by registrar) Huntington for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-31- 1945, at 1 P. M

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malpass M.D.
Medical Examiner.
Date signed 1-31-45

G25362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157a

Registered No. G25362

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rogers Ave & Dobbin St
(c) Hospital or institution Mt Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 15 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ~~Baltimore~~
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 8011 Hillendale Rd #14 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Verzi

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/30/45

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day 15 hr. 44 min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name Salvatore Robert Verzi
13. Birthplace Baltimore

MOTHER
14. Maiden Name Estelle Louise Amass
15. Birthplace Baltimore Co

16 (a) Informant Estelle Louise Verzi
(b) Address 8011 Hillendale Rd. #14

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JAN 31 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 31 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30/1945, at 3:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/30/1945 to 1/30/1945, and that I last saw h[illegible] alive on 1/30/1945.

Immediate cause of death Hydrocephalus — Duration 15 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward C. Day M.D. M.D.
Address W.B.G.H. Date signed 1/30/45

VS 150

2482

625363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625363 Registered No. 1700

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3540 E. Eagle Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gelsomina Del Giudice

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: ~~Annalate~~ Raffaele
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31 1883

8. AGE: Years ~~Days~~ 61 | Months 4 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Romolo Oliva
13. Birthplace Italy

MOTHER
14. Maiden Name Giovannina De Marinis
15. Birthplace Italy

16 (a) Informant Philomena Di Pietro (Dauh.
(b) Address 3510 Claremont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
Address 52 N. Morley St.

19 (a) JAN 31 1945 (Date rec'd by registrar) (b) Thurlington Williams M.D. Registrar

MEDICAL CERTIFICATION 35

20. DATE OF DEATH January 30, 1945, at 7A M

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions Multiple fractures: Lacerations, abrasions, contusions + bruised burns
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-30-45 at 7:30 A.M. 7/2 M.
(b) Where did injury occur? Luzerne & Eagle Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Pedestrian struck by auto

23. Signature Howard F. Mullen M.D. Medical Examiner.
Date signed 1-30-45

VS 151

G25364 (over) G25364

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46B

Registered No. G25364

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 S. Clinton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Concetta ~~Comi~~ Grande Comi

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: W | 6 (a) ~~Single~~, married, ~~widowed or divorced~~: M

6 (b) Name of husband ~~or wife~~: Luigi ~~Comi~~ Comi

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8 1875

8. AGE: Years 69 | Months 1 | Days 22 | If less than one day: hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name late (Antonio ~~Grandi~~) Grande
13. Birthplace Italy

MOTHER
14. Maiden Name Maria Pucci
15. Birthplace Italy

16 (a) Informant Anthony Comi (Son)
(b) Address 1401 S. Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 2/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director (Name) Frank Wells Sons
(b) Address 52 N. Morley St. (29)

19 (a) 1945 (Date filed by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30 1945, at 6:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/3/45 19 , to 1/30/45 19 , and that I last saw her alive on 1/30/45 19 .

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Generalized Post Operative Debility	
Due to Ca Pyloric End of the stomach & Intestinal Obstruction	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)

Date of operation 1/24/45

Major findings of operation: Obstruction due to adhesions - Ca Pylorus

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert B. McFadden M. D.
Address St. Josephs Hospital Date signed 1/30/45

VS 150

G25365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56a

G25365 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days.
(e) Length of stay in Baltimore (yrs., mos., or days) - 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 28 South Robinson Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clara T. Mancini

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-5115

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-6-18

8. AGE: Years 27 | Months | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Silvio Tarsi
13. Birthplace Italy

MOTHER
14. Maiden Name Luisa Ciambruschini
15. Birthplace Italy

16 (a) Informant Frank Mancini (Husband)
(b) Address 28 S. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 3/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd. Baltimore

18 (a) Funeral director Frank Della Noce
(b) Address 52 N. Morley St.

19 (a) 1/31/1945 (Date rec'd by registrar) (b) E. L. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30 1945, at 11:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 1944. to 1-30 1945. and that I last saw h e r alive on 1-30 1945.

Immediate cause of death: Cerebral Thrombosis — Duration

Due to Thrombophlebitis.

Due to Post operative Thrombophlebitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12-28-44

Major findings of operation: Cystic ovary - left

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene J. Riley M. D.
Address St. Joseph's Hospital Date signed 1-30-45

VS 150

83B

G25366 — BALTIMORE CITY HEALTH DEPARTMENT — G25366 Registered No. 107

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibl

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline ST.
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Belnord ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Joseph Kuhn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22 1944

8. AGE: Years	Months	Days	If less than one day
	8	8	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Martin G Kuhn

FATHER 13. Birthplace Balto

MOTHER 14. Maiden Name Frances Schoberg

MOTHER 15. Birthplace Balto

16 (a) Informant Mother

(b) Address 15 N. Belnord AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1st 44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Frank T. Robertson

(b) Address 2718 E. Balto St

FEB 1 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30 1945 at 5 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20 1945 to 1-30 1945 and that I last saw him alive on 1-30 1945

Immediate cause of death	Duration
Laryngo-Tracheo-Bronchitis	
Bronchial Pneumonia	
Due to	
Due to	
Other Conditions	
Mongolian Idiot	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M E Robertson M. D.

Address 1-30-45 Date signed

St Josephs Hospital

VS 150 — Huntington Hilliards, Md.

G25367

BL - 91498

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G25367
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rufus Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Sep.

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9, 1906

8. AGE: Years 38 | Months 10 | Days 20 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John
13. Birthplace Va.

MOTHER
14. Maiden Name Anna Chetman
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date of burial (month) Feb (day) 1 (year) 1945
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director A. Hohenleutner
(b) Address 901 E. Lord Baltimore

19 (a) 1945 Feb 1 (Date rec'd by registrar) Wilson T. Ellis (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29 1945, at 9.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 9 1945, to Jan. 29 1945, and that I last saw him alive on Jan. 28 1945.

Immediate cause of death cellulitis of neck — Duration 3 wks.
(a) contributing terminal toxicity
Due to acute pharyngitis
Due to
Other Conditions sub-acute glomerulonephritis; bronchopneumonia; cellulitis of neck
(Operation and pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Peery, J.
Address City Hosp. Date signed 1-31-45

115c

VS 150

G25368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G25368 / 122 B — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 N. Howard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bernice Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1916

8. AGE: Years 29 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name | 13. Birthplace

MOTHER: 14. Maiden Name | 15. Birthplace

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/29/45 (month) (day) (year)

(c) Cemetery or crematory

Location Bonnie View Sy Ct

18 (a) Funeral director

(b) Address

19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1945 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28 1945 to 1-28 1945 and that I last saw h alive on 1-28 1945.

Immediate cause of death: Peritonitis & shock

Due to: Ruptured intra-abd. abscess

Due to:

Other Conditions: Infect. Obstruction (ileus)

(Include pregnancy within three months of death)

Date of operation 1-28-45

Major findings of operation: Intra-abd abscess & peritonitis

of autopsy: Peritonitis

Duration: 3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. H. Gadelman M. D.

Address Jo H Date signed 1-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G25369 | BALTIMORE CITY HEALTH DEPARTMENT | G25369

CERTIFICATE OF DEATH

X 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 ± + Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Month

2. USUAL RESIDENCE OF DECEASED:
(a) State Newyork (b) County
(c) City or town New York city (If outside city or town limits, write RURAL and give town)
(d) Street No. 860 Park ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Miriam Todd

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Henry Alfred Todd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-13-65

8. AGE: Years 79 | Months 3 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John S. Gilman
13. Birthplace Maine

MOTHER
14. Maiden Name Eliza Wagg
15. Birthplace Pennsylvania

16 (a) Informant Wallace Todd
(b) Address 4616 Alcoma Ave Los Angeles

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 2 1945 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Henry W. Lenhardt Sons
(b) Address McCulloh & McCulloh

19 (a) JAN 31 1945 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1945, at 4:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28 1945, to 1-31 1945 and that I last saw h[illegible] alive on 1-31 1945.

Immediate cause of death: Cardio-Respiratory
Due to Arteriosclerotic Heart Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [redacted]. Frank Supplee M.D.
Address Union Memorial Hospital Date signed 1/30/45 M. D.

X

Meelheim

625370 BALTIMORE CITY HEALTH DEPARTMENT 625370

CERTIFICATE OF DEATH 54a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Del. (b) County
(c) City or town Delmar (If outside city or town limits, write RURAL and give town)
(d) Street No. 510 Jewel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marion E. Meelheim
3 (b) If veteran, name war
3 (c) Social Security Account No. 221-09-6519
4. Sex Fem'l
5. Color or race W.
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) OCT 6-1903
8. AGE: Years 41 Months 3 Days 28 If less than one day hr. min.
9. Birthplace Decorum Co. Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Paul C. Meelheim
13. Birthplace Woodstock Va.
MOTHER 14. Maiden Name Bettie Satchel
15. Birthplace Tabbs Va
16 (a) Informant Mabel Marvel
(b) Address Delmar Del.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-45 (month) (day) (year)
(c) Cemetery or crematory Delmar Memorial
Location Delmar Del.
18 (a) Funeral director John C Miller
(b) Address 243 E Clinton St.
19 (a) 1-3-1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31 1945, at 4 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 1/28 1945 to 1/31 1945 and that I last saw h.l.v. alive on 1/31 1945
Immediate cause of death Respiratory failure — Exsanguination — Duration 5 min.
Due to Medullary compression — 1 hr.
Due to Brain tumor; glioma of fronto parietal lobe
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 1/31/45
Major findings of operation: Glioma, right frontal lobe
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Helen A Jones M. D.
Address Univ. Hospital Date signed 1/31/45

VS 150

625371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 625371

94a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1209 Guilford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 Guilford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter G. Chase

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-1306

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ada L. Chase

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 56 | Months - | Days - | If less than one day: hr. min.

9. Birthplace Dayton Ohio (Town, county, and state)

10. Usual Occupation Motorman

11. Industry or business B. T. Co.

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Unk
15. Birthplace

16 (a) Informant Ada L. Chase
(b) Address 1209 Guilford Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Feb 2/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Fred W. Ozmer
(b) Address 1930 Eastern Ave.

19 FEB 1 - 1945 (Date rec'd by registrar) Huntington Williams M. D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30 1945, at 12 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30 1945, to Jan 30 1945, and that I last saw him alive on Jan 30 1945.

Immediate cause of death

(a) Acute Coronary Thrombosis

Due to Coronary Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: (a) acute, (b) 6 mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(c) Means of injury

23. Signature Harold Stanley M. D.

Address 7007 E. Lombard St. Date signed 9/31/45

G25372 ✓ G25372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5915 Eastern Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5915 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Henry Biemiller

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Anna E. Becker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1865

8. AGE: Years	Months	Days	If less than one day
79	9	20	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name not known
13. Birthplace Germany

MOTHER
14. Maiden Name not known
15. Birthplace Germany

16 (a) Informant Anna I. Biemiller
(b) Address 5915 Eastern Ave.

17 (a) Burial (b) Date thereof Feb. 1, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) Filed record [illegible] FEB 1 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28th 1945, at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 19..., to Jan 28 1945, and that I last saw him alive on Jan 27 19 45.

Immediate cause of death	Duration
Chronic Myocarditis	
Due to Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation ✓
Major findings of operation: ✓
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Adam A. Tod M. D.
Address 1126 Dundalk Ave Date signed Jan 29, 1945

X

625373 ✓ 625373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 918 N Patterson Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 918 N Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rena J Grubb

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1883

8. AGE: Years	Months	Days	If less than one day: hr.	min.
61	2	25		

9. Birthplace Towns Corner Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Reese
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Callahan
15. Birthplace Md

16 (a) Informant Rena Grubb
(b) Address 918 N Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Pulhamus Lodge Inc
(b) Address 1219 E Fort Ave

19 (a) (b) (Date rec'd by registrar) FEB 1 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1945, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-20 1944 to 1-31 1945, and that I last saw her alive on 1-31 1945

Immediate cause of death ARTERIOSCLEROSIS — Duration 3 yrs

Due to UREMIA — 3 wks

Due to

Other Conditions Parkinsons Disease — 14 yr

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James F Kavanagh MD M. D.
Address 1328 McCulloh St Date signed 1-31-45

VS 15

97

G25374 Ethan B. Kline ✓ G25374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1372 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3511 Harford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethan B. Kline

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of ~~husband~~ or wife Mary O. Kline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 1872

8. AGE: Years	Months	Days	If less than one day
72	10	25	hr. min.

9. Birthplace Pa
(Town, county, and state)
10. Usual Occupation Retired Machinist
11. Industry or business Sydenham Hospital

FATHER
12. Name Daniel C Kline
13. Birthplace Pa

MOTHER
14. Maiden Name Nancy Blair
15. Birthplace Pa

16 (a) Informant Arthur N. Kline
(b) Address 8 Lynn Blvd, Upper Darby Pa

17 (a) Burial (b) Date thereof 2/3/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 E Paul St

19 (a) (Date rec'd by registrar) (b) Huntingtor Williams, M.D. Registrar

VS 150 FEB 1 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31 1945, at 1:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/28 1945, to 1/31 1945, and that I last saw h.was alive on 1/31 1945.

Immediate cause of death Hypostatic Pneumonia — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 1/15/45

Major findings of operation: Ca. Prostate Hypostatic Pneumonia

of autopsy: Hypo...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry E Walker M. D.
Address 1400 N. Caroline St Date signed 1/31/45

C25375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

C25375 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Church Home 91
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 20 E. North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Lee Frock

3 (b) If veteran, name war. —
3 (c) Social Security Account No. [illegible]

4. Sex M | 5. Color or race W | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ W

6 (b) Name of husband or wife Florence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30 1865

8. AGE: Years	Months	Days	If less than one day
79	4	0	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired Painter
11. Industry or business Texas R.R.

FATHER
12. Name William Frock
13. Birthplace Maryland

MOTHER
14. Maiden Name Sophie Schwartz
15. Birthplace Maryland

16 (a) Informant Mary Wunsch
(b) Address Lutherville Md

17 (a) Burial (b) Date thereof 2/2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Presbyterian
Location Govans - Local
18 (a) Funeral director William Cook Inc
(b) Address 127 St Paul St.
19 (a) (Date rec'd by registrar) FEB 1 1945 (b) [illegible] Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30 1945, at 8 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29 1945, to 1-30 1945, and that I last saw him alive on 1-30 1945.

Immediate cause of death	Duration
Cerebral thrombosis	5 weeks
Due to Arteriosclerotic heart disease	yrs
Due to	
Other Conditions Chronic generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harris L. Davis M. D.
Address Church Home Date signed 1-30-45

X

625376 ✓ 625376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Landonia Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colored	Widowed

6 (b) Name of husband or wife Will Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1894

8. AGE: Years	Months	Days	If less than one day
50	8	21	hr. min.

9. Birthplace —
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Williams Morley
13. Birthplace —

MOTHER 14. Maiden Name Alice Lake
15. Birthplace —

16 (a) Informant Viola West
(b) Address 822 Harlem ave

17 (a) Burial (b) Date thereof 2-3-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director George D. Nelson
(b) Address 1303 Presstman St

19 (a) (b) Huntington Williams
(Date rec'd by registrar) Registrar

FEB 1 - 1945

VS 22a

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1945, at 9:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1945, to Jan 30 1945, and that I last saw [illegible] alive on Jan 24 1945

Immediate cause of death

Due to Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
6 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Wollan M. D.
Address 841 Harlem Ave Date signed 1/31/45

G25377 ✓ G25377

G25377

JO #91803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 N. Vincent St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Theodore Holland

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Alice (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21 1897

8. AGE: Years 47 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name George Holland (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Eliza Jane Smith (d)
15. Birthplace Md.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 EasternAvenue

17 (a) Burial (b) Date thereof 2-2-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director George H. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (b) Huntington Williams
(Date received by registrar) Registrar

FEB 1 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1945 at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 25, 1945, to Jan. 28, 1945, and that I last saw h im alive on Jan. 28, 1945.

Immediate cause of death: Cachexia — Duration

Due to: Carcinoma of Esophagus & Metastasis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12-18-44

Major findings of operation: Ca abdome

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R L Cutler M. D.
Address City Hosp Date signed 1-31-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625378 BALTIMORE CITY HEALTH DEPARTMENT 625378

CERTIFICATE OF DEATH 92B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2324 W. Cullob
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2324 W. Cullob (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Deanna Wells

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Burnett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-27-1899

8. AGE: Years 44 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county and state)

10. Usual Occupation Home keeper

11. Industry or business

FATHER 12. Name Joseph Myers

13. Birthplace Richmond, Va

MOTHER 14. Maiden Name Caledonia Deaver

15. Birthplace Baltimore

16 (a) Informant Florence Carpenter

(b) Address 1229 Arundel Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. Lawr. H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) (Date received by registrar) (b) FEB 1 1945 Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1945 at 12 36 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1944 to Jan 29 1945 and that I last saw h[illegible] alive on Jan 28 1945

Immediate cause of death Mitral Insufficiency

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Edward Tyler M. D.
Address 2 E. Monument St. Date signed Jan 29/45

625379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830 625379 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1303 Etting St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Etting St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Nelson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Florence Nelson
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Sept 1872

8. AGE: Years 73 | Months 3 | Days 3 | If less than one day hr. min.

9. Birthplace Ashland Va.
(Town, county, and state)

10. Usual Occupation Tailoring

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Florence Nelson
(b) Address 1303 Etting St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem.
Location Baltimore, Md.

18 (a) Funeral director Wm. Geo. H. Hilliard
(b) Address 1631 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29 1945 at 1.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1944 to 1-28 1945 and that I last saw h[illegible] alive on 1-27 1945

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Arteri Sclerosis — 2 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature W. Atwood Jones M. D.
Address 5 S Wolfe St Date signed 1-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

25380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. 25380

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3202 O'Donnell Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3202 O'Donnell St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Colleen MacDonald

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 29, 1941

8. AGE: Years	Months	Days	If less than one day
	3	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward MacDonald
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Josephine Kwiatkowski
15. Birthplace Baltimore, Maryland

16 (a) Informant Edward MacDonald
(b) Address 3202 O'Donnell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1 1945 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem.
Location Dundalk Avenue

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester St.

19 (a) (Date rec'd by registrar) Huntington Williams Registrar

FEB 1 1945

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1945 to 1/30 1945
and that I last saw h[illegible] alive on 1/29 1945

Immediate cause of death: Congenital C.V. disease — Duration

Due to

Due to

Other Conditions Hypostatic Pneumonia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas D. Marsh M.D.
Address 501 N. Eutaw Date signed 1/31/45

381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 625381

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4107 Maine Ave, 7
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Lisansky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Harold
13. Birthplace Russia

MOTHER
14. Maiden Name Fyeida
15. Birthplace Russia

16 (a) Informant Mrs. Esther Lisansky
(b) Address 4107 Maine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-45 (month) (day) (year)

(c) Cemetery or crematory Windsor Mills Rd
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Baltimore St

19 FEB 1 - 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1945, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 29 1945, to Jan 31 1945 and that I last saw h. in alive on Jan 31 1945.

Immediate cause of death Respiratory Failure — Duration

Due to Coronary Thrombosis

Due to

Other Conditions Diabetes mellitis

(Include pregnancy within 3 months of death)

Date of operation None done

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Millard T. Traland M.D.

Address University Hospital Date signed

VS 150

940

G23382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G23382

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St & Rutland Ave
(c) Hospital or institution: Lunair Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2918 Oakley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JENNIE WEINTRAUB

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife William—

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 74 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mussa—
13. Birthplace Russia

MOTHER
14. Maiden Name Fish—
15. Birthplace Russia

16 (a) Informant Harry Weintraub (Son)
(b) Address 2918 Oakley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-45 (month) (day) (year)
(c) Cemetery or crematory Pikesdale
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

FEB 1 — 1945 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31 1945, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/30 1945 to 1/31 1945, and that I last saw h[illegible] alive on 1/31 1945.

Immediate cause of death Pulmonary Edema — Duration

Due to Cardiac failure

Due to Essential Hypertension

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J Simon M. D.
Address Lunair Hospital Date signed 1-31-45

G25383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G25383

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3902 Greenspring Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 Greenspring Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rebecca Silverman

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Abraham Bernard
13. Birthplace Russia

MOTHER
14. Maiden Name Molley
15. Birthplace Russia

16 (a) Informant S. N. Spetner.
(b) Address 3902 Greenspring Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-45 (month) (day) (year)
(c) Cemetery or crematory Pikesville
Location

18 (a) Funeral director Jos. Levin Inc
(b) Address 1439 E. Baltimore St.

FEB 1 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-31-1945 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 19__ to 1-31 1945 and that I last saw her alive on 1-31 1945

Immediate cause of death Cerebral + Spinal Hemorrhage

Duration
Instant
30 days
?

Due to Right Hemiplegia

Due to

Other Conditions Diabetes Insipidus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Kneen B. Kirk M. D.
Address 904 Reed Rd Date signed 1/31/45

83a Rebecca

G25384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G25384

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2241 Ramsay et
(c) Hospital or institution: 20

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2241 Ramsay et (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M Laumann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Dora Laumann
6 (c) If alive, give age 1875 years

7. Birth date of deceased (mo., day, yr.) May 16 - 1875

8. AGE: Years	Months	Days	If less than one day: hr.	min.
69	8	14		1875

9. Birthplace Balto Co Md (Town, county, and state)
10. Usual Occupation Store
11. Industry or business Self.

FATHER
12. Name Laumann
13. Birthplace ~~Balto Co~~ Germany

MOTHER
14. Maiden Name Lucia Rush-
15. Birthplace Balto Co Md

16 (a) Informant Dora Laumann
(b) Address 2241 Ramsay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 2-45 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location

18 (a) Funeral director Charles J Powell
(b) Address 2727 E Monument

19 (a) FEB 1 - 1945 (Date received by registrar)

Transcription for Mitchell MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1945; at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1945 to 1/30 1945, and that I last saw him alive on 1/30 1945.

	Duration
Immediate cause of death Cerebro vascular thrombosis	6 mos.
Due to	
Due to	
Other Conditions Cerebral Thrombosis	4 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D. M. D.
Address 2030 Wilkens ave Date signed 1/31/45

X

625385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1940 Registered No. 625385

Every item of information should be carefully supplied. Please write plainly, with unfading ink. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Long Island N.Y. C.I.P. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lonnie Spaugh

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Agnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10, 1893

8. AGE: Years	Months	Days	If less than one day
51	3	21	hr. min.

9. Birthplace Lawsonville N C (Town, county, and state)
10. Usual Occupation Director
11. Industry or business Piano Industry
FATHER 12. Name Preston Spaugh
13. Birthplace Lawsonville N C
MOTHER 14. Maiden Name Dora Waspaugh
15. Birthplace N C
16 (a) Informant Agnes Spaugh
(b) Address 6 Rushing Rd
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/1/40 (month) (day) (year)
(c) Cemetery or crematory Westminster Mem. Park
Location Catonsville Md
18 (a) Funeral director Wilson & Son
(b) Address 1217 Park Ave
19 (a) (Date rec'd by registrar) (b) Registrar, MD

VS-151 FEB 1 - 1940

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31 1940, at 2:45 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester F. Lubinski M.D.
Medical Examiner.
Date signed 2/2/40

625386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

460 Registered No. 625386

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Union Memorial Hospital
(c) Hospital or institution: See above
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED Anne Arundel
(a) State Maryland (b) County Annapolis
(c) City or town Annapolis (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 Shaw Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Robert B. Hilliard (Grace F.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Robert B. Hilliard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. [illegible], 1884

8. AGE: Years	Months	Days	If less than one day
60	[illegible]	14	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Harry H Powell
13. Birthplace New York

MOTHER
14. Maiden Name Alice F. Randall
15. Birthplace England

16 (a) Informant Mrs. Mary Powell Hilliard
(b) Address 6 Shaw St Annapolis Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/45 (month) (day) (year)
(c) Cemetery or crematory Arlington Nat Cem
Location Arlington Va.

18 (a) Funeral director E. Miller Lamasney
(b) Address 45 Liberty Heights Ave

19 (a) FEB 1 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1945, at 3:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from January 3 1945, to Feb. 1 1945, and that I last saw her alive on Feb. 1 1945.

	Duration
Immediate cause of death Cardio-respiratory failure	
Due to Generalized carcinomatosis and	
Due to Arteriosclerotic heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Carcinoma pancreas

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Jack C Morgan MD M. D.
Address Severn Md Date signed

VS 130

625387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625387 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1925 Ferndale Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Brinwalds (If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 Ferndale Ave (If rural give location)
(e) Citizen of foreign country? GRINNAIS (Yes or No)
If yes, name country

3 (a) FULL NAME Franklin W. Everhardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Wilhelmina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1858

8. AGE: Years	Months	Days	If less than one day
86	1	4	hr. min.

9. Birthplace Detroit, Michigan (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Physician

FATHER
12. Name Philip P. Everhardt
13. Birthplace Detroit, Michigan

MOTHER
14. Maiden Name Julia Edwards
15. Birthplace Richmond Va.

16 (a) Informant Wm. N. Kaer
(b) Address 1925 Ferndale ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-45 (month) (day) (year)
(c) Cemetery or crematory Cremation London Ky
Location Frederick Md

18 (a) Funeral director Jno. C. Miller Inc
(b) Address 2435 E. Oliver St

19 (a) FEB 1 1945 Huntington Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31 1945, at 8:30 M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Charles E. Culbreth M.D. (Medical Examiner.)
Date signed 1/31/45

25388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

625388 Registered No.

Every item of information should be carefully supplied. Please write PLAINLY, WITH UNFADING INK. Erase or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D O A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 W Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Leo Loveless

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Helena L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-21-1887

8. AGE: Years	Months	Days	If less than one day
57	9	6	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Window-trimmer

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Addison H. Loveless
(b) Address 5187 Marathon Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Suitland Md.

18 (a) Funeral director J. W. Tell Sons Co
(b) Address 306-4 St. N.E. Wash. D.C.

19 (a) PER 1-1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 35

20. DATE OF DEATH Jan 27 1945, at 9 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary Edema

Due to Chronic myocardial degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner.)
Date signed Jan 28 1945

VS 151

G25389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1107

G25389 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N.E. Cor. Fremont & Green St.
(c) Hospital or institution:
University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 928 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Eddie Brown Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1945.

8. AGE: Years	Months	Days	If less than one day
0	0	15.	hr. min.

9. Birthplace Baltimore, Maryland. (Town, county, and state)
10. Usual Occupation unemployed.
11. Industry or business

FATHER
12. Name Robert F. Curley Brown.
13. Birthplace Mt. Hope, W. Va.

MOTHER
14. Maiden Name Bernice Gregory
15. Birthplace Jams, W. Va.

16 (a) Informant Mother
(b) Address 928 Druid Hill Ave.

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof 2/1/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemt.
Location Elder Hill Md.

18 (a) Funeral director A. Halsted
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 1945, at Between 5-6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 13, 1945, to Jan. 27 1945, and that I last saw him alive on Jan. 24, 1945.

Immediate cause of death Respiratory failure — Duration

Due to Bronchial Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alma A. Brown-Kelly M.D.
Address Date signed

G25390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

G25390 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 E. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Ross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Nellie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1886

8. AGE: Years 58 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Ross (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah ? (d)
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director J. Halstead
(b) Address 918 Druid Hill Ave

19 (a) (Date received by Registrar) (b) Registrar

EB 1 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 1945 at 11:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15, 1945 to Jan. 22, 1945, and that I last saw him alive on Jan. 22, 1945.

Immediate cause of death Uremia — Duration

Due to Diverticulitis + Recto-vesical fistula

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation Diverticulitis + Recto-vesical fistula

Date of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E J Penny MD

Address BCH Date signed 2-3-45

X

625391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

625391
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Maryland General 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dot
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 527 Orchard St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Floyd Carnish

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75			....hr. ....min.

9. Birthplace ? (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace 3

MOTHER
14. Maiden Name
15. Birthplace 3

16 (a) Informant 3
(b) Address

17 (a) Burial (b) Date thereof 2/1/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Md.
18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.
19 (a) FEB 1945 (b) Huntington Ave Baltimore
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26 1945, 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy-Inspection-Inquest and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?.....
(d) Means of injury.....

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 1/26/45

X

G65392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1370

Registered No. G65392

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & St. Paul

(c) Hospital or institution: Union Memorial Hosp. 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore City

(b) City or town Baltimore #15 10

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3821 Belle Ave

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Samuel Kahn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Viola Kahn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1875

8. AGE:	Years	Months	Days	If less than one day
	69	6	23	hr. min.

9. Birthplace New York

(Town, county, and state)

10. Usual Occupation Builder

11. Industry or business

FATHER

12. Name Salomon Kahn

13. Birthplace ?

MOTHER

14. Maiden Name Hannah ?

15. Birthplace

16 (a) Informant Hosp. Chart

(b) Address

17 (a) Burial (b) Date thereof 2/2/45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery Chev Shalom Cem.

Location Balto. Md.

18 (a) Funeral dir. Blanche Sonnabend & Son

(b) Address 1902 Eutaw Place

19 (a) FEB 1 - 1945 (b) Registrar, M.D.

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1945, at Mt. Vernon M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1945, to Jan 31 1945, and that I last saw him alive on Jan 16 1945.

Immediate cause of death	Duration
Cardio-respiratory	
Due to Coronary heart disease	
Due to	
Other Conditions Hypertrophied prostate	

(Include pregnancy within 3 months of death)

Date of operation: 1-27-45

Major findings of operation: Hypertrophied Prostate

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Geo. W. Houghton Jr. M. D.

Address 337 E. University Pkwy. Date signed 1/31/45

G25393 Jonathon Graybeal X G25393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1861 Registered No.

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Conowingo (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Jonathon Graybeal

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	child —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1943

8. AGE: Years	Months	Days	If less than one day
1	3	29	hr. min.

9. Birthplace Penna. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name W. Harold Graybeal
13. Birthplace N.C.

MOTHER 14. Maiden Name Estes Rogerson
15. Birthplace Washington, D.C.

16 (a) Informant Fred Califfman
(b) Address Peach Bottom Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Little Britain
Location Lancaster County, Pa.

18 (a) Funeral director C. P. Rogers
(b) Address 35 N. 4th St Oxford Pa.

19 (a) 1945 (Date received by registrar) (b) Huntington Mills, Registrar

FEB 1

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-31- 1945 at 8:10 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-31-45 at P. M.
(b) Where did injury occur? Conowingo, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury while playing, fell down a flight of steps

23. Signature Howard A. Hendricks M.D.
Medical Examiner.
Date signed 2-1-45

X

G25394

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G25394

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital - D.S.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 61 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL FEB 1 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 FEB 1 - 1945 Hugh H. Williams, M.D. Registrar
(Date rec'd by registrar)

2483

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/18 1945, at 1 00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C. V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature C. Sutton Lubrinski M.D.
Medical Examiner.

Date signed 1/16/45

625395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1159

Registered No. 625395

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 11 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1145 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-28-45

8. AGE: Years	Months	Days	If less than one day
			11 hrs. 5 mins

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Albert Allen
13. Birthplace Scottsville Va.

MOTHER
14. Maiden Name Dorothy Waddy
15. Birthplace Balto. Md.

16 (a) Informant Albert Allen
(b) Address 1145 N. Mount St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 1 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 1 - 1945 Hunting for Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29-1945, at 12 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28 1945 to 1-29-1945, and that I last saw her alive on 1-29-1945.

Immediate cause of death

	Duration
Prematurity	
Due to	
Due to	
Other Conditions No	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. J. Slatcher M.D.
Address 1220 Park Ave Date signed 1/30/45

VS 150

2484

625396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓108

625396 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: Univ Hosp 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Unk.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 946 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Zackes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Margia Zackes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20, 1891

8. AGE: Years 54 | Months | Days 11 | If less than one day hr. min.

9. Birthplace Bruce (Town, county, and state)

10. Usual Occupation Proprietor Confectionery

11. Industry or business

FATHER
12. Name John Unk Zackes
13. Birthplace Greece

MOTHER
14. Maiden Name Catherine Unk Zanados
15. Birthplace Greece

16 (a) Informant Mrs. Margie Zackes
(b) Address 946 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/45 (month) (day) (year)
(c) Cemetery or crematory Bair National Cem
Location 5501 Fred Road

18 (a) Funeral director John J. Corpas & Son
(b) Address 901-03 Hollins St

19 (a) (Date rec'd by registrar) (b) (Registrar)

FEB 1 - 1945

Hunter for Mitchell

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-31-45 19 at 5 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31 1945 to 1-31 1945, and that I last saw him alive on 1-31 1945

Immediate cause of death Asphyxia due to
Due to Pulmonary Pneumonia
Due to Overwhelming Infection
Other Conditions Possible Pneu. Septicemia
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

Duration

G25397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G25397
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Any correction, age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John. Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 131 S. Caroline St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Prentiss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1899

8. AGE: Years 45 | Months 9 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace New Kent Co., Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Henry Christain
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Coddwell
15. Birthplace Va.

16 (a) Informant Mary Brown
(b) Address 1121 - 23rd Street - Newport News, Va.

17 (a) Burial (b) Date thereof 2/2/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location New Port News, Va.

18 (a) Funeral director Elvey O. Wilson
(b) Address 1000 Bryant Ave

19 (a) 1945 (b) Clayton Williams, M.D. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30 1945 at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Broncho pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Clayton J. Williams M.D.
Medical Examiner.
Date signed 4/27/45

G25398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G25398 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs 10 min
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 N. Linwood (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Walker

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/31/45

8. AGE: Years	Months	Days	If less than one day
			7 hr. 16 min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Lott. William Walker
13. Birthplace Pikesville, Md.

MOTHER
14. Maiden Name Dorothy E. Cooke
15. Birthplace Belair, Md.

16 (a) Informant Mrs. Lott. Walker
(b) Address 706 Linwood - Balto. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 2 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Lebanon
Location Baltimore Md

18 (a) Funeral director P. Thomas Fett
(b) Address Same

19 (a) FEB 1 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31/45 19 40 05/12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/31 1945 to 1/31 1945
and that I last saw him alive on 1/31 1945

Immediate cause of death
Congenital atelectasis
Due to Prematurity

Duration
7 hrs.

Due to

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elizabeth Hetrick, M.D.
Address Hosp. for Women of Md. Date signed 2/1/45 (M. D.)

G25393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G25393 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette and John Streets
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 73 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2248 Brookfield Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Kaufman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age / years

7. Birth date of deceased (mo., day, yr.) Dec 3 1871

8. AGE: Years	Months	Days	If less than one day
73	1	28	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Charles Kaufman
13. Birthplace Germany

MOTHER
14. Maiden Name Babette Stern
15. Birthplace Germany

16 (a) Informant Mr. Lawrence Kaufman
(b) Address 2248 Brookfield Ave., Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 2 45 (month) (day) (year)
(c) Cemetery or crematory Pikesville Cemetery
Location Old Court Rd

18 (a) Funeral director J. Abrams & Co
(b) Address 2432 Reisterstown Rd

19 (a) FEB 1 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31, 1945, at 12:36 AM

21. I certify that death occurred on the date above stated; that I attended deceased from January 25, 1945, to January 31, 1945, and that I last saw her alive on January 31, 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension Cardiovascular and arteriosclerotic Heart Disease	
Due to Generalized arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. H. Speed M.D.
Address Women's Hospital Date signed 1-31-45

VS 2

625100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 625400

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 64

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4314 Colborne Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. George W. Johnson

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife: Clara Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 15th 1877

8. AGE: Years 67 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace: Balto Md. (Town, county, and state)

10. Usual Occupation: Candy Manufacturer

11. Industry or business: Self

FATHER
12. Name: George W. Johnson
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Mary Fatuna
15. Birthplace: Md

16 (a) Informant: Earl L. Johnson
(b) Address: 32 S. Calvert st

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/5/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul st

19 FEB 2 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/1 1945 at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/26 1945 to 2/1 1945, and that I last saw h~~im~~ alive on 2/1 1945

Immediate cause of death	Duration
Cerebral Embolism	
Due to Auricular Fibrillation	
Due to Arteriosclerotic C.V. Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Martin E. Strobel M. D.
Address: Md. Genl. Hospital Date signed 2/1/45

VS 150

X

G25401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G25401

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4547 Schenley Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 4547 Schenley Rd (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

14

3 (a) FULL NAME Blanche B. Anders

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband Frank W. Anders

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14th 1885

8. AGE: Years	Months	Days	If less than one day
57	8	17	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business At Home

FATHER 12. Name William Brown

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden Name Edith Anthony

MOTHER 15. Birthplace Balto Md.

16 (a) Informant Frank Anders

(b) Address 4547 Schenley Rd.

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 2/3/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Maryland Park

Location Parkville Md

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) FEB 2 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31st 1945; at 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1944, to Jan 31 1945, and that I last saw h.e alive on Jan 30 1945.

	Duration
Immediate cause of death Acute Coronary Occlusion	3 days
Due to Hypertensive Cardiovascular disease	7 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)

(e) Means of injury —

23. Signature Frances W. Gluck M. D.

Address 715 Park Ave Date signed 1/31/45

Gluck X

G 25402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92d Registered No. G 25402

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave. & Belvedere
(c) Hospital or institution:
Hebrew Home for Aged Infirm.
(d) Length of stay in hospital or inst. (yrs., ~~xxxxxxxx~~) 1
(e) Length of stay in Baltimore (yrs., ~~xxxxxxxx~~) 35

2. USUAL RESIDENCE OF DECEASED: 1-19
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Greenspring
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Riva Chanevitz (Rebecca Chanowitz)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow

6 (b) Name of husband or wife Benj.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Zadel
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Mrs. Broth (daughter)
(b) Address 2009 Edmondson Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location

18 (a) Funeral director Jack Lewis, Inc.
(b) Address 1439 E. Baltimore Street

19 (a) Feb. 2, 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1, 1945 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1941, to Feb. 1, 1945.
and that I last saw her alive on Feb. 1, 1945

	Duration
Immediate cause of death Hemmorragic infarction of lung	
Due to Chronic endocarditis of mitral valve	
Due to	
Other Conditions generalized arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature A. Broth
M. D.
Address 3505 N. Charles St Date signed 2-19-45

VS 150

625403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

✓ 625403 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 834 N. Rutland Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John Reisis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business Restaurant Business

FATHER
12. Name.....
13. Birthplace Greek

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant Mike Reisis
(b) Address 839 Rutland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 3 1945 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox Cem Interglenmore
Location Balto, Md.

18 (a) Funeral director Frainers Reese
(b) Address Undertaker

19 (a) FEB 2 (Date rec'd by registrar) (b) 1945 Hunting [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 1945, at 5 30 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Preston M.D.
Medical Examiner.
Date signed Feb. 1 1945

VS 151

625404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

625404
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 348 S Woodyear
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 348 S Woodyear (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles J Mosmiller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Gertrude F

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24 87

8. AGE: Years 57 | Months 1 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation R. R. Carman

11. Industry or business

FATHER 12. Name Joseph Mosmiller
13. Birthplace Md

MOTHER 14. Maiden Name Emma Neuman
15. Birthplace Md

16 (a) Informant Mrs C J Mosmiller
(b) Address 348 S Woodyear st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director George A Farley
(b) Address Fulton & Fayette sts

19 (a) 1945 (Date received by registrar) (b) Huntington Williams (Registrar)

B 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1945, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944, to Jan 31 1945, and that I last saw h[im] alive on 1/31 1945.

Immediate cause of death Carcinoma of bladder — Duration 1 Yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D.
Address 1020 W Fayette Date signed 2/4/45

VS 150

awc X

625405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 D

625405 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Eaton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2925 Walbrook Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Virginia Feldman

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband ~~or wife~~ Elmer R. Feldman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1881

8. AGE: Years	Months	Days	If less than one day
63	4	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Waters
13. Birthplace Frederick Co.

MOTHER
14. Maiden Name Lillie E. Schreyer
15. Birthplace Washington, D. C.

16 (a) Informant Mr. Elmer R. Feldman
(b) Address 2925 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 3 - 1945 (Date received by registrar) Huntington Willis Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1, 1945 at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 29 1945 to Feb 1, 1945 and that I last saw her alive on Feb 1, 1945

Immediate cause of death	Duration
Heart failure	
Due to Chronic myocardial degeneration	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Williams J. Bryan M. D.
Address St. Agnes Hosp Date signed 2/3/45

(over)

X

625406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

625406 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 340 S. Augusta Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 340 S. Augusta Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma C. Albrecht

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Theodore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1873

8. AGE: Years 71 | Months 8 | Days 17 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name Joseph Reahl
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Aurick
15. Birthplace Germany

16 (a) Informant Wilbur J. albrecht
(b) Address 340 S. Augusta ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 2/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Little
(b) Address 401 Edmondson ave

19 (a) (Registered by Registrar) (b) Registrar

FEB 2 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30, 1945 at 4:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to Jan 30 1945, and that I last saw her alive on Jan 30 1945.

Immediate cause of death	Duration
Coronary occlusion	3 days
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Allen M. D.
Address 332 Frederick Ave Date signed 2-1-45

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G25407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G25407

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline ST.
(c) Hospital or institution: St Josephs Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 dd
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6406 Old Harford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah D. Streb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph C. Streb

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Feb. 17 - 1871

8. AGE: Years 73 | Months 11 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Charles Kelly

13. Birthplace Ireland

MOTHER 14. Maiden Name Sarah Rowe

15. Birthplace Ireland

16 (a) Informant Mrs. Joseph C. Streb

(b) Address 6406 Old Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore

18 (a) Funeral director Leonard J. Luck

(b) Address 5305 Harford Rd

19 (a) (Date rec'd by Registrar) FEB 2 - (b) 1945 Registrar

VS 150

Huntington for Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-1 1945 at 1.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-27 1945, to 2-1 1945, and that I last saw her alive on 2-1 1945.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Chronic Myocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.

Address St Josephs Hosp Date signed 2-4-45

X

625408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

625408 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 E. 26th St
(c) Hospital or institution: 9/8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 11 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 E. 26th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Steele

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1850

8. AGE: Years: 94 | Months: 2 | Days: 18 | If less than one day: 19 hr. min.

9. Birthplace London, England (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name John Larey
13. Birthplace England

MOTHER
14. Maiden Name Alice Montague
15. Birthplace England

16 (a) Informant Mrs. Harry Steele
(b) Address 507 E. 26th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 2, 1945 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore County

18 (a) Funeral director O. R. Slade
(b) Address 4907 York Rd.

19 (a) (Date received by registrar) FEB 2 - 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30 1945, at 12:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McCallum M.D. Medical Examiner.
Date signed 1/31/45

VS 151

25409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G25409

AB-91869

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 253 N. Bruce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Baynor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23- 1894

8. AGE: Years 50 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Lloyd Baynor (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Massey (D)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City and

18 (a) Funeral director Joseph A. Linsky
(b) Address 4 N Mount Street

19 FEB 2 1945 Huntington Williams M.D.
(Date rec'd by Registrar) (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31- 1945, at 2.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-30 1945 to 1-31- 1945, and that I last saw h. im alive on 1-31- 1945.

Immediate cause of death myocardial failure — Duration

Due to hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. A. Parry M.D.
Address City Hosp. Date signed 1-31-45

X

G25410
JL - 15447

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH / 31a

G25410
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR STAMPING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days): 22- 0 - 24
(e) Length of stay in Baltimore (yrs., mos., or days): 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: Baltimore City Hospitals (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Mollie E. Karns

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 22, 1862

8. AGE: Years	Months	Days	If less than one day
82	1	8	hr. min.

9. Birthplace: Pa. (Town, county, and state)
10. Usual Occupation: Domestic
11. Industry or business:

FATHER
12. Name: John Karns
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Martha Ashbaugh
15. Birthplace: Pa.

16 (a) Informant: B. C. H. Records
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-45 (month) (day) (year)
(c) Cemetery or crematory: Sh. Peters
Location: Parkton Md.

18 (a) Funeral director: Charles W. Kuchnyaska
(b) Address: 703 McHenry St.

19 (a) FEB 7 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 30 1945, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6, 1925 to Jan. 30 1945, and that I last saw her alive on Jan. 30 1945.

Immediate cause of death	Duration
Coronary occlusion	1 day
Terminal Pneumonia	?
Due to arteriosclerosis	
Due to	
Other Conditions Chronic Vascular Nephritis Pulmonary edema.	?

*(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: E. Woodward M. D.
Address: Baltimore City Hospitals Date signed 2-1-45

VS 150

G25411 AUGUSTUS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G25411

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1179 South Ann St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18d

(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city limits, write RURAL and give town)

(d) Street No. 1179 South Ann St (If rural, give location)

(e) Citizen of foreign country? N (Yes or No)

If yes, name country

3 (a) FULL NAME John Augustus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Flora Augustus

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) August 25, 1864

8. AGE: Years 80 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER 12. Name Jacob Augustus

13. Birthplace Va. Virginia

MOTHER 14. Maiden name Martha Agnes Cline

15. Birthplace Va. Va.

16 (a) Informant Flora Augustus

(b) Address 1179 S. Ann St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 2, 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Mrs Kate R Williams

(b) Address 322 N. Schroeder St

19 (a) Date received by local registrar Huntington Williams, M.D.

FEB 2 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31/45 19 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/5/44 to 1/31/45 and that I last saw ... alive on 1/30/45

Immediate cause of death Cerebral Hemorrhage 4 Days

Due to Paralysis about 1 month

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Hobart Ellis M. D.

Address [illegible] Date signed 2/1/45

625412 (2)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625412 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3006 Harford Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9r
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Harford Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August A. Gassinger
3 (b) If veteran, name war No. | 3 (c) Social Security Account No. [redacted]6-5251
4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Mary
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 18 1865
8. AGE: Years 79 | Months 5 | Days 13 | If less than one day hr. min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business
FATHER 12. Name August Gassinger
FATHER 13. Birthplace Germany
MOTHER 14. Maiden Name
MOTHER 15. Birthplace Germany
16 (a) Informant August F Gassinger
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 5 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd
18 (a) Funeral director Mark McDonald & Sons
(b) Address 7110 Belair Rd
19 (a) Filed FEB 2 1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1945, at 11:35 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1945, to Jan 31 1945, and that I last saw h[illegible] alive on Jan 31 1945.

Immediate cause of death Cardiac failure — Duration 3 months
Due to Pulmonary Edema
Due to Chronic myocardial [illegible]
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William C. Mitchell M.D.
Address 10 W. Madison St. Date signed 2/3/45

VS 180

G25413

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95B

G25413 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2632 Garrett Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. VALERIO

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-01-4214

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of ~~husband~~ or wife Incoronata (nee Manti)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1918

8. AGE: Years	Months	Days	If less than one day
27 yrs.	-	26	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Crown Cork & Seal

FATHER
12. Name Antonio Valerio
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Natala
15. Birthplace Italy

16 (a) Informant Staffanio Valerio (brother)
(b) Address 2835 Fleetwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/45 (month) (day) (year)
(c) Cemetery or ~~Church~~ Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) FEB 2 1945 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 1945, at 3:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 21, 1945 to Feb. 3, 1945 and that I last saw him alive on Feb. 2, 1945.

Immediate cause of death Cardio - Respiratory Failure — Duration
Due to Pulmonary edema
Due to Myocardial insufficiency; rheumatic heart disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley K. Steinberg M.D.
Address Linia Hospital Date signed 2/6/45

625414

340709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625414 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1801 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna A. Prochaska.

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-1231

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White.	married

6 (b) Name of husband or wife John V.

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 1-14-95

8. AGE: Years	Months	Days	If less than one day
50		15	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Mathew Melka

13. Birthplace Bozech.

MOTHER 14. Maiden Name Mary Zitnik

15. Birthplace Bozech.

16 (a) Informant Records. JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/2/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek

(b) Address 2601 E. Madison Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

FEB 2 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan-29- 1945, at 11.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-27 1945 to Jan-29 1945, and that I last saw her alive on Jan-29 1945.

Immediate cause of death	Duration
Heart Failure	
Due to: ? Coronary Occlusion	
Due to: Hypertensive + arterio-sclerotic heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence Stickney M.D.

Address Johns Hopkins Date signed 1/30/45

G25415 ✓ G25415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 710 N. Duncan St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cyril Skala, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-7181

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Marie (nee Benda)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-25-87

8. AGE: Years 57 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business Armour & Company

FATHER
12. Name Frank Skala
13. Birthplace Bohemia

MOTHER
14. Maiden Name Barbara Nemec
15. Birthplace Bohemia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/45 (month) (day) (year)
(c) Cemetery or XXXX Oak Hill
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) 2 1945 (Date rec'd by registrar) (b) Hilton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1945 to Jan 31 1945 and that I last saw him alive on Jan 31 1945

Immediate cause of death	Duration
pulmonary infarct	3 months
Due to pneumonia & empyema	
Due to	
Other Conditions Ca oesophagus	

(Include pregnancy within 3 months of death)

Date of operation 1-24-45

Major findings of operation: inoperable Ca of oesophagus

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George Bunch, M. D.
Address J. H. H. Date signed 2-1-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

625416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 625416

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3037 Arunah Avenue
(c) Hospital or institution: ARUNAH
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 85

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3037 Arunah Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME PERCY L. SLAUGHTER

3 (b) If veteran, name war No

3 (c) Social Security Account No. 2/370-7540

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Grace E. Slaughter

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Jan 5, 1888

8. AGE: Years 57 | Months | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Fordsville Va.
(Town, county, and state)

10. Usual Occupation Construction Engineer

11. Industry or business McLane Contracting Co

FATHER
12. Name ——— Slaughter
13. Birthplace Va

MOTHER
14. Maiden Name Dont know
15. Birthplace Va

16 (a) Informant Mrs Garnetta Slaughter
(b) Address 3037 Arunah Ave

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Feb 3/1945 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Balto City

18 (a) Funeral director A. Howard Evans
(b) Address 1400 Bb Harbor

19 (a) ——— (Date rec'd by registrar) **(b)** ——— Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1, 1945, at 3:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions Coronary Thrombosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? ____ While at work?
(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner
Date signed Feb. 1, 1945

65417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No. 65417

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Give correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3317 Dudley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3317 Dudley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Hugel

3 (b) If veteran, name war: no

3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: ~~Widowed~~ Divorced

6 (b) Name of husband or wife: Elsa Hugel

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Apr 19. 1879

8. AGE: Years 65 | Months 9 | Days 17 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Letter Carrier

11. Industry or business

FATHER 12. Name William Hugel
13. Birthplace Germany

MOTHER 14. Maiden Name Emma Eberich
15. Birthplace Germany

16 (a) Informant John L. Hugel
(b) Address 3200 Eastmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5. 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Mrs. John W. Teufel Son
(b) Address 801 W. Fayette St.

19 (a) (Signature of registrar) (b) Huntington Williams, M.D.

FEB 2 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1945 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27 1945 to Jan 31 1945 and that I last saw ~~him~~ alive on Jan. 31 1945

Immediate cause of death: Cerebral Thrombosis — Duration: 5 days
Left sided Hemiplegia
Due to Cerebral Arteriosclerosis
General Arteriosclerosis
Due to
Other Conditions Hypertension
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Vincent F. Joska M.D. M. D.
Address 845 N. Patterson Pk. Ave Date signed 2/1/45

625418 BALTIMORE CITY HEALTH DEPARTMENT X ✓ 6 Registered No. 625418

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 Balto. Md.
(c) Hospital or institution: South Baltimore Gen'l Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A.A. Co.
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. Cedar Hill Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Paul Reinecke ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1 1943

8. AGE: Years 2 | Months 2 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Paul Reinecke, Sr.
13. Birthplace Severn, Md.

MOTHER
14. Maiden Name Pearl Leake
15. Birthplace Virginia

16 (a) Informant Mrs. Paul Reinecke Sr.
(b) Address Cedar Hill Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/45 (month) (day) (year)

(c) Cemetery or crematory
Location Cedar Hill Lane

18 (a) Funeral director John Denny, Inc.
(b) Address

19 FEB 2 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1, 1945, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Meningococcus Septicemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature ROBERT LEE GRAHAM, M.D. Medical Examiner.
Date signed February 2 1945
Howard J. Thomsen, M.D.

625419 ✓ X 625419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1062

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 & Calvert
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Towson. (If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Bosley Ave. (If rural give location)
(e) Citizen of foreign country? O. (Yes or No)
If yes, name country

3 (a) FULL NAME Winfield Stafford Hayes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Infant

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1 1944.

8. AGE: Years	Months	Days	If less than one day
	6	0	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Baby
11. Industry or business

FATHER
12. Name William Glen Hayes
13. Birthplace Md.

MOTHER
14. Maiden Name Jo Rose Stafford
15. Birthplace New Jersey.

16 (a) Informant Father
(b) Address 500 Bosley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Md.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.

FEB 2 - 1945 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 1945 at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Feb 1 1945 and that I last saw h~~im~~ alive on Feb 1 1945

Immediate cause of death Tracheobronchitis — Duration
Peripheral collapse
Upper respiratory infection
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature — Paul S. Gross M. D.
Address Union Memorial Hospital Date signed 2-4-45

VS 150

625420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 3aD

625420 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 N. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES STEFANKIEWICZ (STEVENS)

3 (b) If veteran, name war: W.W.#1

3 (c) Social Security Account No. 212 09 7255

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MARY STEFANKIEWICZ

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT.25 1894

8. AGE: Years	Months	Days	If less than one day
50	4	6	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation TIME KEEPER

11. Industry or business

FATHER
12. Name WILLIAM STEFANKIEWICZ
13. Birthplace GERMANY

MOTHER
14. Maiden Name ANTONI KARABAN
15. Birthplace GERMANY

16 (a) Informant MARY STEFANKIEWICZ (WIFE)
(b) Address 112 N.PATTERSON PARK AVE.

17 (a) BURIAL (b) Date thereof FEB. 3/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory US.NATIONAL
Location FREDERICK ROAD

18 (a) Funeral director Lidy & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) FEB 2 1945 (b) Registrar
(Date rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-31- 1945 at 4 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Syphilitic aortitis

Due to

Other Conditions Coronary Disease
Chronic Myocarditis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 1-31-45

625421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. 625421

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 931 S. BOULDIN ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 931 S. BOULDIN ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENA NEAL

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife SAMUEL NEAL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 30 1888

8. AGE: Years	Months	Days	If less than one day
57	8	29	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name FREDERICK KEGEL
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name BARBARA HORNER
15. Birthplace BALTO. MD.

16 (a) Informant SAMUEL NEAL (HUS.)
(b) Address 931 S. BOULDIN ST.

17 (a) BURIAL (b) Date thereof FEB. 3/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE EXT.

18 (a) Funeral director Lilly & Zeller Sons.
(b) Address 403 S. WOLFE ST.

19 (a) (Date received by Registrar) FEB 2 1945 (b) Registrar

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH JAN. 30 1945 at 1/30M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Jan 30 1945 and that I last saw her alive on Jan 30 1945

Immediate cause of death	Duration
Acute Edema of Lungs	
Due to Chronic Myocardial Insufficiency	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene Zeller, M.D.
Address 2739 Eastern Ave Date signed 1/31/45 (M. D.)

VS 150

X

G25122 ✓ G25122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30F

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 72 days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Whiteford (If outside city or town limits, write RURAL and give town)
(d) Street No. none (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Beverly Canter

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months: 5 | Days | If less than one day: hr. min.

9. Birthplace: Md (Town, county, and state)
10. Usual Occupation: infant
11. Industry or business

FATHER
12. Name: Lewis Leonard
13. Birthplace

MOTHER
14. Maiden Name: Edith Canter
15. Birthplace

16 (a) Informant: Edith Canter
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: JOHN HOPKINS MEDICAL SCHOOL FEB 2 1945

18 (a) Funeral director: Commissioner of Health
(b) Address

19 FEB 2 - 1945 Harold F. Williams, M.D.
(Date rec'd by registrar)

VS 150

2487

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27 1945, at 5:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10 1944, to 1-27 1945 and that I last saw her alive on 1-27 1945

Immediate cause of death: Malnutrition — Duration: Since Birth

Due to: Congenital Syphilis Born at 8 months, 3 lbs

Due to:

Other Conditions: Prematurity

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Donald Gleason M. D.
Address: Univ Hosp. Date signed 1-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

625423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

625423 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 101 Wendover Road

(c) Hospital or institution: at home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 | 2

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 101 Wendover Rd (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME John M. Requardt

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Victoria A. Requardt

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) March-16-1876

8. AGE: Years 68 | Months 8 | Days 16 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business Law

FATHER — 12. Name John Fred'k Requardt

13. Birthplace Germany

MOTHER — 14. Maiden Name Bertha Jaeger

15. Birthplace Germany

16 (a) Informant Mrs J M Requardt - wife

(b) Address 101 Wendover Rd.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Feb-3-45 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Baltimore

18 (a) Funeral director Stewart Mayer & Co.

(b) Address 108 W Mt Royal

19 (a) (Filed) by registrar FEB 2 1945 (b) Huntington, West Virginia, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 1945, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/5/44 19 to 2/1 1945

and that I last saw him alive on 1/19 1945.

Immediate cause of death: Cerebral Haemorrhage

Due to: Arterio-Sclerosis Cardiac Hypertrophy

Due to: Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Walter C Bacher M. D.

Address 1115 St Paul St Date signed 2/2/45

X

G25421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓ Registered No. G25421

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave. and John St.
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 70yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 2707 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Virginia Diggs Williss

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 18, 1859

8. AGE: Years 85 | Months 4 | Days 13 | If less than one day hr. min.

9. Birthplace Matthews Court House, Virginia
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Robert T. Diggs
13. Birthplace Virginia

MOTHER
14. Maiden Name Eliza A Smith
15. Birthplace Virginia

16 (a) Informant Mr. John R. Williss (Son)
(b) Address 2707 Guilford Ave., Baltimore, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 3/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Stewart & Company
(b) Address 1050 Eutaw Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 3 FEB 2 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31, 1945, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 16, 1945, to January 31 1945, and that I last saw her alive on January 31 1945.

Immediate cause of death: Arteriosclerotic Cardio-Vascular Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. S. Baird III M. D.
Address Women's Hospital Date signed 1-31-45

G25425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G25425

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave. and John St.
(c) Hospital or institution:
Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 Mt. Royal Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anne Lacy Reese

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: Single
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 16 1865

8. AGE: Years: 79 | Months: 11 | Days: 18 | If less than one day: hr. min.

9. Birthplace Baltimore County, Maryland
(Town, county, and state)

10. Usual Occupation Home maker

11. Industry or business

FATHER
12. Name Henry Reese
13. Birthplace Md.

MOTHER
14. Maiden Name Mary A. Miller
15. Birthplace D.C.

16 (a) Informant Miss Caroline Reese (Sister)
(b) Address 1405 Mt. Royal Ave. - City

17 (a) Burial (b) Date thereof 2-5-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Friends
Location Harford & 25th St. Balto.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

19 (a) (Date rec'd by registrar) (b) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2, 1945, at 4:14 AM

21. I certify that death occurred on the date above stated; that I attended deceased from February 1, 1945, to February 3, 1945, and that I last saw her alive on February 2, 1945.

Immediate cause of death: Respiratory failure — Duration:

Due to Bilateral hypostatic + pulmonary edema

Due to Carcinomatosis, Generalized

Other Conditions Due to: Adeno-carcinoma, Rt. breast
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. E. Ford III M. D.

Address Veterans Hospital Date signed 2-2-46

VS 3

625426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E 625426 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 622-E-33rd St
(c) Hospital or institution: at Home 9-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 46yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 622-E-33. St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME John Crawford Paterson

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E. Paterson
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Jan-21-1873

8. AGE: Years 72 | Months 0 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Arnot-Penna (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business Law

FATHER 12. Name Henry Paterson
13. Birthplace Scotland

MOTHER 14. Maiden Name Elizabeth Stagg
15. Birthplace Scotland

16 (a) Informant Miss Elizabeth M. Paterson (daughter)
(b) Address 622-E-33-Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb-3-45 (month) (day) (year)
(c) Cemetery or crematory David Hoge Cem
Location

18 (a) Funeral director Stewart & Mowen Co.
(b) Address 108 W North Ave.

19 (a) FEB 2 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1945 to Jan 31 1945, and that I last saw h alive on Jan 31 1945

Immediate cause of death	Duration
Myocarditis,	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation None
of autopsy:

PHYSICIAN
—Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence None at M
(c) Where did injury occur (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A Keane M. D.
Address 612 W 40 St Date signed

VS 150

625427 BALTIMORE CITY HEALTH DEPARTMENT 625427

CERTIFICATE OF DEATH 56 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Co.
(c) City or town Rural - Halethorpe
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 Lewallon Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucie Bates

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Hurley Bates

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14, 1914

8. AGE: Years 30 | Months 11 12 | Days 17 | If less than one day hr. min.

9. Birthplace Crystal Hill Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jones Chapel
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Bolton
15. Birthplace Va.

16 (a) Informant Hurley Bates
(b) Address 1501 Lewallon Lane

17 (a) Shipped to (Burial, cremation, or removal) (b) Date thereof Feb. 3, '45. (month) (day) (year)
(c) Cemetery or crematory Crystal Hill
Location Virginia

18 (a) Funeral director Katie R. William
(b) Address 322 N. Schroeder St.

19 (a) FEB 2 - 1945 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31 1945, at 7.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25-1945, to 1-31-1945, and that I last saw h. alive on 1-31-1945.

Immediate cause of death	Duration
Post operative obstruction	2 day.
Acute Cardiac Dilatation	1 day.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1-27-45

Major findings of operation: Myomata uteri c adhesions —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address 1207 N Caroline St. Date signed 2/2/45 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G25428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

G25428 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 22 d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Northumberland (If outside city or town limits, write RURAL and give town)
(d) Street No. 491 Duke St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gwendolyn Swank Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-5-20

8. AGE: Years 24 | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Harness Millworker

11. Industry or business

FATHER
12. Name Clark H.
13. Birthplace Pa.

MOTHER
14. Maiden Name Bessie Gilbert
15. Birthplace N.J.

16 (a) Informant Records. JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-45 (month) (day) (year)
(c) Cemetery or crematory Promfort Cemetery
Location SUNBURY PENNA.

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1910 Eutaw Place

19 (a) FEB 2 - 1945 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1945 at 10 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1945 to Feb 2 1945 and that I last saw her alive on Feb 2 1945.

Immediate cause of death Bronchopneumonia - post operative. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1/31/45

Major findings of operation: Diverticulosis of sigmoid - left tubo-ovarian abscess.

of autopsy: — wall perforated.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lewis W. Chambers M.D.
Address Johns Hopkins Hospital Baltimore Md. Date signed 2/2/45

G25429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G25423
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1532 N. Gay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1532 N. Gay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A Zink

3 (b) If veteran, name war: —
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Lillie
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) April 19, 1877

8. AGE: Years	Months	Days	If less than one day
67	9	12	hr. min.

9. Birthplace Baltimore Md
(town, county, and state)

10. Usual Occupation Wholesale Liq
11. Industry or business

FATHER 12. Name Angelus
13. Birthplace Germany

MOTHER 14. Maiden Name Mary McKelter
15. Birthplace Germany

16 (a) Informant Lillie Zink
(b) Address 1532 N Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/45 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Baltimore Md

18 (a) Funeral director Fuhrman & Lee
(b) Address 1219 E Fort Ave

19 (a) FEB 2 1945 (date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1945, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1945, to Feb 2 1945, and that I last saw him alive on Feb 1 1945.

Immediate cause of death — Duration

Bronchopneumonia — 3 days.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Just Fuchs M. D.
Address 183 W. Mosh St. Date signed 2/2/45

625430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

625430 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1733 Hanover St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Murphy

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband ~~or wife~~ James H. Murphy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 27th 1865

8. AGE: Years	Months	Days	If less than one day
79	2	4	....hr. ....min.

9. Birthplace Tilghman Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business Self

FATHER
12. Name Charles Clemmings
13. Birthplace Tilghman Md.

MOTHER
14. Maiden Name Sarah Harrison
15. Birthplace Tilghman Md.

16 (a) Informant Roland Murphy
(b) Address 5243 Long Point Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-45 (month) (day) (year)
(c) Cemetery or crematory Tilghman Md
Location Tilghman Md

18 (a) Funeral director Wilson Conner
(b) Address 1217 Light St

19 (a) 1945 (Date rec'd by registrar) (b) Huntington Willis Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-1-45 19.... at 3:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29 1945 to 2-1 1945, and that I last saw h~~er~~ alive on 2-1 1945.

Immediate cause of death Bronchio-pneumonia.
Back of brain
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles R. Marshall M. D.
Address 1213 Light St Date signed 2-4-45

625431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625431 Registered No. 131B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts.
(c) Hospital or institution Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3309 Haywood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis G. Ludwig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/7/1877

8. AGE: Years 67 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Ella M. Hess
(b) Address 3309 Haywood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Lorenz Byers
(b) Address 500 Park Heights Ave

19 (a) 1945 (Registered by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-1 1945 at 10 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-18 1945 to 2-1 1945. and that I last saw h(im) alive on 2-1 1945.

Immediate cause of death Uremia — 3 Duration
from chronic glomerulo nephritis
Due to
Due to
Other Conditions See peritonitis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy Nephritis Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Cal Myers M.D.
Address Franklin Square Hosp. Date signed 2-1-45 M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

G25432 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1926 W. Mulberry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1926 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Schenkel.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Wm. Schenkel.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25, 1854

8. AGE: Years 90 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name John Holman
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Daniel F. Schenkel
(b) Address 4707 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director Irving Byers.
(b) Address 5005 Park Heights Ave

FEB 2 - 1945 (Date rec'd by registrar) (b) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 1945 at 5 P. M Ja

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Feb 1 1945; and that I last saw her alive on Jan 30 1945

Immediate cause of death	Duration
Pneumonia	10 days
Due to Arteriosclerosis, Nephritis	
Due to Senility	
Other Conditions Bedsores (2 weeks)	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles J. Wells M. D.
Address 5276 Park Hgts Date signed Feb 2 45

VS 150

625433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 625433 (new)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 S. Paca ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George G. Cully ~~George G. Cully~~

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age ~~1891~~ years

7. Birth date of deceased (mo., day, yr.) July 28, ~~1895~~ 1891

8. AGE: Years	Months	Days	If less than one day
53 ~~65~~	6	-0	hr. min.

9. Birthplace Mc Calls Ferry, Penna.
(Town, county, and state)

10. Usual Occupation Life Insurance Agent

11. Industry or business

FATHER
12. Name George G. Cully Sr.
13. Birthplace Mc Calls Ferry Pa.

MOTHER
14. Maiden Name Mary M. Stubble
15. Birthplace Mc Calls Ferry, Pa.

16 (a) Informant Milton Cully
(b) Address Perryville, Md.

17 (a) CB (Burial, cremation, or removal) (b) Date thereof Feb 5, 1945 (month) (day) (year)

(c) Cemetery or crematory St Marks
Location Perryville Md.

18 (a) Funeral director Patterson & Son
(b) Address Perryville Md.

19 (a) 1945 (Date rec'd by registrar) (b) Livingston Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1945, at 11 ~~45~~ AM

21. I certify that I took charge of the remains described above, held an Inquisition thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular-renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Grotheer M.D.
Medical Examiner.
Date signed Jan 28 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 91 C

625434 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3911 Northern PKwy.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7 5
(e) Length of stay in Baltimore (yrs., mos., or days) 6 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3911 Northern PKwy. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Doris Pels Harrington

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Robert N. Harrington
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 18th 1923

8. AGE: Years 21 | Months 23 | Days 3 | If less than one day hr. min. 13

9. Birthplace N. Y. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Harry Pels
13. Birthplace Kentucky

MOTHER
14. Maiden Name Hazel Champlain
15. Birthplace N. Y.

16 (a) Informant R. N. Harrington
(b) Address 3911 Northern PKwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 (month) 5 (day) 45 (year)
(c) Cemetery or crematory Evergreen
Location Brooklyn N. Y.

18 (a) Funeral director Lasadan Funeral Home
(b) Address 7401 Belair Rd.

FEB 3 - 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 45 1945, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 45 to Feb 12 1945, and that I last saw h e alive on Feb 12 1945

Immediate cause of death: Pulmonale Embolism
Due to: Thrombophlebitis
Due to: Endocarditis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: Today / 24 hrs / 3 wks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edward B Easter
Address 116 Oradell Date signed 2/2/45

G25435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G25435 Registered No.

G25435

#0 #91763

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1828 E. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Janet Louise Jennings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1943

8. AGE:	Years	Months	Days	If less than one day
	-1-	-2-	24	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Jennings
13. Birthplace Va.

MOTHER
14. Maiden Name Victoria Pickett
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof February 5 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location 2 A County Md.

18 (a) Funeral director Mrs. Robert A. Elliott & Sons
(b) Address 1129 N. Caroline Street

19 (a) (Date rec'd by registrar) (b) Huntington Md. Registrar

FEB 7 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31, 1945, at 7:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23, 1945, to Jan. 31, 1945, and that I last saw her alive on Jan. 31, 1945.

Immediate cause of death	Duration
Tuberculous Meningitis	3wd.
Due to Tuberculosis.	?
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hugh W. Jones M. D.
Address B. C. H. Date signed 2/3/45

625436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625436 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hosp
(c) Hospital or institution:
2005 W. Fayette St

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State md. (b) County Orneles
(c) City or town Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 Madeline Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ellen Dodson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Mr. Emory Dodson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16th 1893

8. AGE: Years	Months	Days	If less than one day
51	11	17	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Wm Thomas
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Harberts
15. Birthplace Germany

16 (a) Informant Wm Thomas
(b) Address 19 Madaline Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 5 45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 2401 Belair Rd.

19 (a) (Date received by Registrar) (b) Registrar

FEB 3 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2 1945, at 12.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/30 1945 to 2/2 1945, and that I last saw her alive on 2/2 1945.

Immediate cause of death	Duration
Pneumococcic Meningitis	6 days
Due to Suppurative Otitis Media	10 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard C. Hayden, M. D.
Address Bon Secours Date signed 2/2/45

VS 150

Hunting for Williams, Md.

625437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

625437
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp. 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4406 Powell Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry L. Sieling

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-05-3063

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Clara M. Sieling
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Sept. 5th 1886

8. AGE: Years	Months	Days	If less than one day
58	4	29	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name Charles H. Sieling
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary E. (or Eliz.) Shoemaker
15. Birthplace Baltimore Md.

16 (a) Informant Clara M. Sieling
(b) Address 4404 Powell Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 5 45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Lansdale Funeral Home
(b) Address 7401 Belair Rd.

19 (a) FEB 3 1945 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2 1945, at 10:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/18 1945 to 2/2 1945, and that I last saw him alive on 2/2 1945.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers
Address Franklin Sq. Hosp. Date signed 2/2/45 (M. D.)

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G25438 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1013 E. Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Callahan Sr.

3 (b) If veteran, name war — None —
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary A. Callahan (nee McCormick)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 20, 1869

8. AGE: Years 75 | Months 10 | Days 11 | If less than one day hr. min. 12

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Retired Foreman
11. Industry or business Standard Oil Co.

FATHER
12. Name Cormie Callahan
13. Birthplace Ireland

MOTHER
14. Maiden Name Anna Corcoran
15. Birthplace Ireland

16 (a) Informant Mr. John J. Callahan Jr.
(b) Address 1013 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5, 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location 4300 Old Frederick Rd.

18 (a) Funeral director Edmund D. Coughlin & Son
(b) Address 924 E. Eager St.

19 (a) FEB 3 1945 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 19 45, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 19 45, to 1/31 19 45, and that I last saw him alive on 1/31 19 45

Immediate cause of death	Duration
Acute coronary infarction	
Due to Coronary Sclerosis	
Due to Generalarteriosclerosis	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Argyle St Date signed 2/3/45

G25439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G25439

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Portugal Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marie G. Tanzziolla (Mary G. Tazzole)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5 —?

8. AGE Years about 35 | Months 6 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Lawrence Barton
13. Birthplace Maryland

MOTHER
14. Maiden Name Florence Musgrove
15. Birthplace Maryland

16 (a) Informant Mrs. Mabel Todd
(b) Address 2076 Rockrose Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 3-1945 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Hamboden
Location Baltimore, Maryland

18 (a) Funeral director Durgee Funeral Home
(b) Address 3631 Falls Road
(c) FEB 3 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30, 1945, at 11 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subdural Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Jan 31 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830a

625440 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General 15 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dot
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 W North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August J. Hergenroeder

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Julia G. Hergenroeder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1884

8. AGE: Years	Months	Days	If less than one day
60	6	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired - Freight Conductor
11. Industry or business B. & O. Railroad

FATHER
12. Name Sylvester Hergenroeder
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine (Unknown)
15. Birthplace Germany

16 (a) Informant Mrs. Julia G. Hergenroeder
(b) Address 2911 W. North Ave.

17 (a) Burial (b) Date thereof 2/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Huntington Williams M.D.
(Date received by registrar) Registrar

FEB 9 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/1 1945, at 8:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester A. Jackson M.D.
Medical Examiner.
Date signed 2/7/45

625441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1228

625441 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert Sts

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 1 2d

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. Esplanade Apts Entrance Woodbourne Lane (If rural give location)

(e) Citizen of foreign country? O (Yes or No)

If yes, name country

3 (a) FULL NAME Rosa B. Makel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: married Widow

6 (b) Name of husband or wife Mr. Philip Makel

6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) March 29, 1866

8. AGE: Years 78 | Months 10 | Days 3 | If less than one day ....hr. ....min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER 12. Name Mr. John Kerth

13. Birthplace Germany

MOTHER 14. Maiden Name Rosa Vogel

15. Birthplace Germany

16 (a) Informant Mrs. Blanche R. Bamesh

(b) Address Esplanade Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/45 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem

Location Woodlawn, Md.

18 (a) Funeral director Wm. J. Fiske & Son

(b) Address Balto., Md.

19 (a) ....(Date rec'd by reg'r) FEB 3 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2, 1945 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1945 to Feb 2 1945 and that I last saw her alive on Feb 2 1945.

Immediate cause of death	Duration
Cardio respiratory failure due to arteriosclerotic heart disease	
Due to	
Due to Intestinal obstruction	1 wk.
Other Conditions Bronchial asthma	

(Include pregnancy within 3 months of death)

Date of operation 1-31-45

Major findings of operation: Intestinal obstruction due to adhesions

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ....at ....M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Dr. Fred. Hawkins Jr. M. D.

Address Union Memorial Hosp Date signed 2-2-45

X

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25442 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH — 83a — Registered No. G25442

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~940~~
(c) Hospital or institution: Mercy Hospital, Baltimore Md. 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 940 Webb Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Robert Bartlett (Robert H. Bartlett)
3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Grace E. Bartlett
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 10, 1879

8. AGE: Years	Months	Days	If less than one day
65	9	21	...hr. ...min.

9. Birthplace Virginia (Alexandria) (Town, county, and state)
10. Usual Occupation Methodist Minister
11. Industry or business

FATHER
12. Name John Henry Bartlett
13. Birthplace D. C.

MOTHER
14. Maiden Name Caroline West
15. Birthplace Germany

16 (a) Informant Miss Caroline E. Bartlett
(b) Address 1801 Bolton St.
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/4/45 (month) (day) (year)
(c) Cemetery or crematory Alexandria, Va.
Location
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) ... (Date rec'd by registrar) (b) ... Registrar

FEB 5 1945 Huntington Hospital

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1945, at 11:55 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30 1945, to Feb 1 1945, and that I last saw him alive on Feb 1 1945.

Immediate cause of death	Duration
Circulatory failure	
Due to Cerebral hemorrhage	2 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Roy Bayron Turner, Jr., M. D.
Address Mercy Hospital Date signed 2/2/45

X

625443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

625443 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1739 Braddish Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1739 Braddish Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Snapp

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Joseph Snapp

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27 1874

8. AGE: Years 70 | Months 3 | Days 5. | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Blanchfield.

13. Birthplace Va.

MOTHER 14. Maiden Name Ellen Betz.

15. Birthplace Va.

16 (a) Informant Joseph Snapp

(b) Address 1739 Braddish Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2- -45 (month) (day) (year)

(c) Cemetery or crematory Good Shepherd.

Location Rockland, Howard Co. Md.

18 (a) Funeral director H. Howard Strong

(b) Address 3707 W. North Ave

19 (a) FEB 3 1945 (Registrar's signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1. 1945 at 7.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Feb 1st 1945.
and that I last saw him alive on Feb 1st 1945.

Immediate cause of death Acute Dilatation of Heart - Pulmonary Edema — Duration 3 days

Due to Chronic Myocarditis — 4 years

Due to Chronic Interstitial Nephritis — 4 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. C. Brunsk M. D.
Address 4209 Gelbert Ave. Date signed Feb 5

VS 130

X

G25444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G25444

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hosp. Bal. Hos. 2344
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Months
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3828 Brooklyn Ave. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Augustus D. Craig

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widowed

6 (b) Name of husband or wife Annie C. Craig

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 7-1898

8. AGE: Years	Months	Days	If less than one day
56	6	25	..... hr. ..... min.

9. Birthplace North Carolina (Town, county and state)

10. Usual Occupation machinist

11. Industry or business Linen Thread Co.

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mr. August B. Craig
(b) Address 3828 Brooklyn Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd.

19 (a) FEB 3 1945 Date rec'd by Registrar (b) Emmitt for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-2- 1945, at 12:10 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....

Coronary Disease

Due to.....

Other Conditions Acute Pulmonary Edema.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury.....

23. Signature Howard J. Walden M.D. Medical Examiner.
Date signed 2-2-45

G25445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered No. G25445

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 W. Franklin
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Gross

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-1847

4. Sex M | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. ~~Widowed~~

6 (b) Name of husband or wife Ruth Gross

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1897

8. AGE: Years 47 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Harry Gross.
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mary Tripps.
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ruth Gross (wife)
(b) Address 1312 N. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 2 - '45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Katie R. Wilkins
(b) Address 322 N. Schroeder St.

19 (a) Feb 2 1945 (b) Huntington Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30 1945, at 8 00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to Jan 30 1945.
and that I last saw h[illegible] alive on Jan 6 1945.

Immediate cause of death

Cancer of Throat

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 yr. 22

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Reba W. Rechtin

Address 426 W. John St. Date signed Feb 2 1945

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

625446
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 657 W Barre Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Roy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-18-45

8. AGE: Years | Months: 2 | Days: 13 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Leroy Savage
13. Birthplace md.

MOTHER
14. Maiden Name Dorothy Roy
15. Birthplace md.

16 (a) Informant Dorothy Savage
(b) Address 657 W Barre St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy A. Watson
(b) Address 1000 Belmont Ave

19 (a) FEB 3 - 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1, 1945, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Lev death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobular pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb 2 1945

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

625447 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 252 N. Schroeder St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black.	

6 (b) Name of husband or wife Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-27-93

8. AGE: Years	Months	Days	If less than one day
51	8	7	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Norvill Wiggins
13. Birthplace Va.

MOTHER
14. Maiden Name ? ? ?
15. Birthplace ? ? ?

16 (a) Informant Record. JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/45 (month) (day) (year)
(c) Cemetery or crematory Middlesex Co. Va
Location Va

18 (a) Funeral director Geo. H. Nelson
(b) Address 1303 Pressman st

19 (a) 2-3-45 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

C

20. DATE OF DEATH Feb. 1 1945 at 11.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Feb 1 1945 and that I last saw h[illegible] alive on Feb 1 1945

Immediate cause of death ? Cerebrovascular accident — Duration 10hrs

Due to

Due to ? uremia

Other Conditions Hypertensive vascular disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Dixon
Address Johns Hopkins Hosp. Date signed 2/2/45

VS 150

G2-148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G2-148

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2035 Division St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-9
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2035 Division St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Bessie E. Washington

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Otis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/23/1900

8. AGE: Years 44 | Months 9 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Wash D.C. (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name Sophia Hill
15. Birthplace Md

16 (a) Informant Evelyn Frank
(b) Address 2036 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/45 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Geo. H. Kelso
(b) Address 1303 Pressman St

19 (a) 2-3-45 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1945, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1945, to 2-2 1945; and that I last saw her alive on 2-2 1945.

	Duration
Immediate cause of death: Cancer of Stomach	6 mos
Due to: Metastasis from Carcinoma of Breast	1 yr.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature G. M. Lift M.D.
Address 15-36 W Lanvale St Date signed 2-3-45

G-6449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G-6449

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1344 N Stricker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1344 N Stricker St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Louise Nelson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Dave
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 74 | Months 73 | Days | If less than one day ... hr. ... min.

9. Birthplace Wash. D. C
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Henry Jackson
13. Birthplace Wash. D.C

MOTHER
14. Maiden Name Martha
15. Birthplace Wash. D.C

16 (a) Informant Jessie Bush
(b) Address 1344 N. Stricker St

17 (a) Burial (b) Date thereof 2/1/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Md

18 (a) Funeral director Wm H. Nelson
(b) Address 1303 Brentwood St

19 (a) 2-3-45 (b) ...
(Date rec'd by registrar) Registrar

VS 3.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-1 1945, at 6a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1. 1945 to 2-1 1945 and that I last saw her alive on 2-1 1945.

Immediate cause of death Cardia Renal Edema — Duration 1 yr.

Due to Hypertension X Kidney.

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature C. N. Pigott M.D.
Address 1536 W. Lanvale St. Date signed 2-3-45

X

625450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93F

625450 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2421 Woodbrook Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2421 Woodbrook Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME James H. Sheppard.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Mary E. Sheppard.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26, 1862

8. AGE: Years	Months	Days	If less than one day
82	5	6	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Sheppard.
13. Birthplace Md.

MOTHER
14. Maiden Name -
15. Birthplace Md.

16 (a) Informant Mary E. Sheppard.
(b) Address 2421 Woodbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Preastmans

19 (a) 2-3-45 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1945; at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1945 to Feb 1 1945 and that I last saw him alive on Feb 1 1945

Immediate cause of death	Duration
Myocarditis	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations none
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. M. Lawrence M. D.
Address 1033 W. Lanvale St Date signed 2/3/45

VS 3

625451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 625451

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Walbrook Laundry
(a) Baltimore City, Maryland
(b) Street address 1911 Dukeland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write R.D., or Rural, and give town)
(d) Street No. 711 Allegany Place (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Delice Lee

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-3404

4. Sex: female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife James Lee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/1/1892

8. AGE: Years 52 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER
12. Name unobtainable
13. Birthplace Va

MOTHER
14. Maiden Name unobtainable
15. Birthplace Va.

16 (a) Informant James Lee
(b) Address 711 Allegany Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md.

18 (a) Funeral director Jos. D. Kelly
(b) Address 1303 Pennsylvania Ave

19 (a) 2-3-45 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1, 1945, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed February 2, 1945.

625452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625452 107

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Street
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kenneth Rice Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-18-45

8. AGE: Years | Months | Days: 17 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Ernest Hopkins
13. Birthplace Md.

MOTHER
14. Maiden Name Rosia Morris
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Darlington Md
Location Darlington Md

18 (a) Funeral director H. E. Bailey
(b) Address Darlington Md.

19 (a) FEB 1 1945 (Date filed by Registrar) (b) Huntingtown Willis Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Feb. 3 1945, at 2.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 22 1945 to Feb 3 1945, and that I last saw him alive on Jan Feb 3 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Bronchitis capillary	3 days
Pectoral atelectasis	"
Due to Congenital deformity of lower jaw and palate (micrognathia)	life
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pectoral atelectasis (minimal)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ruth Whitemore M. D.
Address Johns Hopkins Hospital Date signed 2/3/45

G25453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

G25453 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 301 Beechfield Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Schumacher

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-1124

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maria Schumacher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 9, 1884

8. AGE: Years	Months	Days	If less than one day
60	2	14	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Stock Keeper
11. Industry or business Hutzler Bros.

FATHER
12. Name Franz Schumacher
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna Burkhardt
15. Birthplace Germany

16 (a) Informant Walter Wm. Schumacher
(b) Address 1333 Bentwood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-45 (month) (day) (year)
(c) Cemetery or crematory [redacted]
Location Baltimore, Md.

18 (a) Funeral director George H. Schwab
(b) Address 2101 Frederick Avenue

19 (a) FEB 4 - 1945 (Date received by Registrar) (b) Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2, 1945, at 7:45 P. M.

21. I certify that I took charge of the remains described above, held an Inspection + Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Compound, comminuted fracture of the Skull with avulsion of brain tissue.

Other Conditions Multiple fractures, lacerations, abrasions, and bad burns.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-2-45 at 7:05 A 28-4 M.
(b) Where did injury occur? Fred Decker Rd. & Beechfield Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury? Pedestrian struck by automobile

23. Signature Howard J. Malpass M.D.
Medical Examiner.
Date signed February 3, 1945.

VS 151

G25454 BALTIMORE CITY HEALTH DEPARTMENT G25454
Registered No.

CERTIFICATE OF DEATH 12a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1717 Eastern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAUL BRAGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Reba Feinberg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1889

8. AGE: Years 55 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Lunch Room

FATHER
12. Name Isaac Brager
13. Birthplace Russia

MOTHER
14. Maiden Name Mary ?
15. Birthplace Russia

16 (a) Informant Reba Brager
(b) Address 1717 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 4, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave & Phila Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Huntington Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 2 1945 1130P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1944 to Feb 6 1945, and that I last saw him alive on Feb 6 1945

Immediate cause of death	Duration
Cardiac Failure	
Due to Hemiplegia	
Due to Hypertensive cardio-vascular renal disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Isadore Shorofsky MD
Address 601 N. Monroe St Date signed 2/2/45

VS 150

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

625455 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2919 Norfolk Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Amolsky

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Octoberl, 1883

8. AGE: Years 61 | Months 4 | Days - | If less than one day hr. min.

9. Birthplace Wilkes Barre, Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER — 12. Name Louis Amolsky
13. Birthplace Riga

MOTHER — 14. Maiden Name Katherine Siegel
15. Birthplace Riga

16 (a) Informant Minnie Milliman
(b) Address 2919 Norfolk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 4, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location Sol Levinson & Bros 1124-1126 W North Ave

18 (a) Funeral director
(b) Address

19 (a) 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 1 1945 at 1029 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26-1945 to 2-1-1945 and that I last saw her alive on 2-1-1945

Immediate cause of death Respiratory failure — Duration

Due to Coronary Heart Disease

Due to Decompensation Acute Pulmonary Edema

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen C. Wooden M. D.
Address W. B. G. H. Date signed 2-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c 625456 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4661 Pimlico Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 34yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4661 Pimlico Road

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Philip Levin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1909

8. AGE: Years 35 | Months 8 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Book Shop

FATHER

12. Name Jacob Levin

13. Birthplace Russia

MOTHER

14. Maiden Name Mary Levin

15. Birthplace Russia

16 (a) Informant Jacob Levin

(b) Address 4661 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 4, 1945 (month) (day) (year)

(c) Cemetery or crematory Wash Blvd.

Location

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-1126 W North Ave

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

FEB 1945

Huntington Williams, Md

VS 130

MEDICAL CERTIFICATION 9.10

20. DATE OF DEATH February 3, 1945, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1944 to 2/3 1945, and that I last saw h. liv. alive on 2/2 1945.

Immediate cause of death: Coronary Thrombosis — Duration: Sudden

Due to: Aberrantic Cardiovascular — Duration: Years

Due to: Disease — Duration:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Joseph S. Blum M. D.

Address 1206 E. Lee St Date signed 2/3/45

625457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625457

Registered No. 1942

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 16 W Lanvale St

(c) Hospital or institution: 2

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County ~~Balto~~

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 16 W Lanvale St (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) **FULL NAME** Margaret Collins

3 (b) If veteran, name war No

3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Frederick Collins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 31, 1866

8. AGE: Years	Months	Days	If less than one day
79		2	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER — 12. Name	James Sprecol
FATHER — 13. Birthplace	New Jersey
MOTHER — 14. Maiden Name	Margaret Fayla
MOTHER — 15. Birthplace	Va

16 (a) Informant Clarence Collins

(b) Address 16 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5, 1945 (month), (day), (year)

(c) Cemetery or crematory Cedar Hill

Location A. G. Co.

18 (a) Funeral director A. Howard Evans

(b) Address 140 S Charles St

19 (a) FEB 1 - 1945 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1945 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1945 to Feb 2 1945 and that I last saw h alive on 19

Immediate cause of death	Duration
Angina Pectoris	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. M. Mellis M.D.

Address 1279 Mulberry St Date signed

Hunterstown approved by Howard J. Mellis, M.D. X

VS 150

625458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

625458
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2304 Gallow Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 Gallow Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BARBARA NEIMON

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Hyman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Russia (Town, County, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Louis Goodman
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Abraham Sachs
(b) Address 3812 Bell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-45 (month) (day) (year)
(c) Cemetery or crematory Adath Israel
Location Balto Md

18 (a) Funeral director Sachs Sons Inc.
(b) Address 1439 E. Balto St

(a) FEB 4 - 1945 (Date rec'd by Registrar) (b) Huntington Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-2-45 19 , at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943, to Feb 2 1945, and that I last saw h[illegible] alive on June 11th 1945.

Immediate cause of death Coronary occlusion — Duration
Due to hypertension heart disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Bix M. D.
Address 2516 Linden Ave Date signed 2-2-45

Harold Bix

G25459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G25459
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3803 Woodbine
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3803 Woodbine
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Marburg (MYERBERT)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Abraham —
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland

16 (a) Informant Mrs Rose Myerberg
(b) Address 3803 Woodbine Ave

17 (a) Burial (b) Date thereof 2-4-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory United Hebrew Cem.
Location Washington Blvd's

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) 2-4-1945 (b) Huntington Williams
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2, 1945, at 2:30 AM

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner.
Date signed Feb. 2, 1945.

G25460 TYSKA G25460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1209 Hull Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 Hull Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Tyska

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-09-3396

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Veronica Tyska

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) May 17 1903

8. AGE: Years 41 | Months 8 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Rigging Clerk

11. Industry or business Bethlehem Fairfield

FATHER — 12. Name Roman Tyska

FATHER — 13. Birthplace Poland

MOTHER — 14. Maiden Name Minnie Krupinski

MOTHER — 15. Birthplace Poland

16 (a) Informant Mrs Veronica Tyska

(b) Address 1209 Hull St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-1945 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location A. A. Co. Md.

18 (a) Funeral director Flynn & Flynn

(b) Address 1426 Light St.

19 (a) Hastings for Williams, MD

(Date received by registrar) Registrar

FEB 4 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2, 1945, at 8:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mulder M.D.
Medical Examiner.

Date signed Feb. 3, 1945.

Dr. Jacobs
1701 Eutaw Place
G25461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G25461

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8101 Old Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Staylor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1861

8. AGE: Years	Months	Days	If less than one day
83	5	18	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George W. Staylor
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Washington
15. Birthplace Va.

16 (a) Informant Mr. William F. L. Thomas
(b) Address 8101 Old Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) Huntington Williams, Registrar

FEB 4 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 - 1945, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-30 - 1945, to 1-31 - 1945, and that I last saw him alive on 1-31 - 1945

Immediate cause of death — Duration
Terminal Pneumonia
Due to Exposure after accident
Due to
Other Conditions Adv. Atherosclerosis Myocarditis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis L. Jacobs M. D.
Address 1700 Eutaw Pl. Date signed 2-3-45

Dr. Schurich 625462
So. Charles St.

625462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4517 Mainfield Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4517 Mainfield Avenue
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Adelaide Cronin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Cyril A. Cronin
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1901

8. AGE: Years	Months	Days	If less than one day
43	4	13	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Clinton L. Smith
13. Birthplace Baltimore Co.

MOTHER
14. Maiden Name Annie T. Hines
15. Birthplace Baltimore Co.

16 (a) Informant Mr. Cyril A. Cronin
(b) Address 4517 Mainfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) FEB 4 1945 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2, 1945, at 3 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14, 1944 to Feb 2 1945, and that I last saw h alive on Feb 1 1945.

Immediate cause of death, Carcinoma - Left Ovary. — Duration

Due to

Due to

Other Conditions Thyroid Carcinoma & Myxomatoid Degeneration

(Include pregnancy within 3 months of death)

Date of operation Nov 25, 1944

Major findings of operation: Carcinomatous nodules throughout abdomen

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Schurich M. D.
Address 1337 S. Charles St Date signed 2/3/45

X

625463 BALTIMORE CITY HEALTH DEPARTMENT X ✓ 625463
CERTIFICATE OF DEATH 55E Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil Co.
(c) City or town Elkton.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rnte 1.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Safia.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married.

6 (b) Name of husband or wife Michael Safia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-21-99

8. AGE: Years	Months	Days	If less than one day
45	-	2	hr. min.

9. Birthplace Poland.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Stan Weglo
13. Birthplace Poland.

MOTHER
14. Maiden Name Sofia Slawikowska
15. Birthplace Poland

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (b) Date thereof Feb 8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Elkton Catholic Cem.
Location Elkton Md

18 (a) Funeral director Jr. W. Coffin & Son
(b) Address Elkton Md.

2-5-1945 (b) Huntington Mills Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-3 1945, at 6 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11 1945 to 2-3 1945 and that I last saw h- alive on 2-3 1945.

	Duration
Immediate cause of death Shock	1 hr.
Due to Pulmonary embolus	1 hr.
Due to Phlebothrombosis L. femoral	22-4d.
Other Conditions Epidermoid sp. cervix blastoma 3 cent T4-S1 (Include pregnancy within 3 months of death)	

Date of operation 1-17-45, 2-3-45
Major findings of operation: Epid. Sp. Ca. 4 cent, phlebothr. L. fem.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature P. Whittlesey M. D.
Address J. H. H. Date signed 2-3

VS 180

625464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

625464 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 Chest Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME (James P. McNamee) JOSEPH PATRICK McNAMEE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth

6 (c) If alive, give age: 1894 years

7. Birth date of deceased (mo., day, yr.): June 15 1895

8. AGE: Years: 49 | Months: 7 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Jackson Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Patrick McNamee
13. Birthplace: Penna

MOTHER
14. Maiden Name: Julia Ruttee
15. Birthplace: Md

16 (a) Informant: Funeral Director (Chas H. Drews)
(b) Address: 920 Main St Upper Darby Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb 7 1945 (month) (day) (year)
(c) Cemetery or crematory: Mt Zion
Location: Ardmore, Penna

18 (a) Funeral director: Wm Cook Lee
(b) Address: 1217 St Paul St Balto

19 (a) FEB 5 - 1945 (b) Huntington Williams M.D.
Date rec'd by Local Reg. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-2- 1945, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Lobar Pneumonia

Due to:

Other Conditions: Fibrinous pleurisy

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: Homer J. Medeiros M.D. Medical Examiner.
Date signed 2-3-45

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~65465~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. 65465

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1.0.0.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 681 W. Fayette Street
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ewing L. Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No. 22-07-5370

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband or~~ wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4th 1886

8. AGE: Years	Months	Days	If less than one day
58	8	28	hr. min.

9. Birthplace Point Marion Pa
(Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Maritime Commission

FATHER
12. Name William Robinson
13. Birthplace Pa.

MOTHER
14. Maiden Name Mariam Crow
15. Birthplace Pa.

16 (a) Informant Elizabeth Robinson
(b) Address 681 W. Fayette St.

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 2/6/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) FEB 5 1945 (Date received by Registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 1945, at 11:30 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fatty degeneration of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb. 2nd 1945

625466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625466 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 221 N. High St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard F. Blue

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of ~~husband or~~ wife Margaret Blue

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15th 1874

8. AGE: Years	Months	Days	If less than one day
70	5	17	hr. min.

9. Birthplace Brooklyn N. Y.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name (Unknown) Blue
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Dorothy Miller
(b) Address 3304 Richmond Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Md

18 (a) Funeral director Wilson Cook Inc
(b) Address 1219 N. Howard St

19 (a) FEB 5 - 1945 (Date rec'd by registrar) (b) Huntington Willis Rochat M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2 1945 at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Thrombosis C.V.D. 1 year

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. C. Sabusky M.D.
Medical Examiner.
Date signed 2/3/45

VS 151

625467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. 625467

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAKE NO MARKS IN SPACE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John
(c) Hospital or institution: Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24d.
(e) Length of stay in Baltimore (yrs., mos., or days) 62yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Ruxton
(If outside city or town limits, write RURAL and give town)
(d) Street No. Malvern Aye.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Jesse Leathe H. Meyer

3 (b) If veteran, name war W
3 (c) Social Security Account No. unk

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Herman F
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1882

8. AGE: Years 62 | Months 4 | Days 20 | 19 If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Arthur W. Hanks
13. Birthplace Va

MOTHER
14. Maiden Name Jennie Leache
15. Birthplace Va

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) FEB 5 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1945, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1945, to Feb. 1945, and that I last saw her alive on Feb. 3, 1945.

Immediate cause of death Arteriosclerosis
with Coronary Occlusion

Due to

Due to

Other Conditions Pelvic Abscess
Pericarditis
(Include pregnancy within 3 months of death)

Date of operation 1/10/45

Major findings of operation: Volvulus of ileum.

of autopsy: Well healed anastomosis

Duration
Months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest E. Bamfield M.D. M. D.
Address Woman's Hosp. Date signed 2/3/45

X

625468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95 C

Registered No. G25468

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2601 E. Monument St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2601 E. Monument St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William A. De Mott

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Eunice De Mott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 22nd 1866

8. AGE: Years 78 | Months 5 | Days 10 | If less than one day: hr. min.

9. Birthplace Girard Pa.

(Town, county, and state)

10. Usual Occupation Dancing Instructor

11. Industry or business Self

FATHER

12. Name James De Mott

13. Birthplace Unknown

MOTHER

14. Maiden Name Josephine Tournaire

15. Birthplace Unknown

16 (a) Informant Eunice De Mott

(b) Address 2601 E. Monument St

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 2/5/45

(month) (day) (year)

(c) Cemetery ~~or crematory~~ Parkwood

Location Parkville Md.

18 (a) Funeral director William Dork Inc

(b) Address 1257 St. Paul St

19 (a) Date received (month) (day) (year) FEB 5 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2nd 1945 at 4a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944 to ~~Feb~~ 2 1945, and that I last saw him alive on Feb 1 1945.

Immediate cause of death	Duration
myocardial insufficiency	5 days
Due to arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature L. C. Schlund M.D.

Address 447 N. Kenwood Ave. Date signed 2/5/45

X

65469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

Registered No. 65469

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1805 Asquith St
(c) Hospital or institution: GH
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 Asquith St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kathleen G. Ferguson

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of ~~husband or wife~~ Edward L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 9 1890

8. AGE: Years	Months	Days	If less than one day
48	1	22	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name James Kernan
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Kate O'Rourke
15. Birthplace Balto Md.

16 (a) Informant Edward L. Ferguson
(b) Address 1805 Asquith St.

17 (a) Burial (b) Date thereof 2/5/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Fernon
Location White Hall Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (a) FEB 5 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1st 1945, at 3:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1944, to Feb 1 1945, and that I last saw h alive on Feb 1 1945

Immediate cause of death	Duration
(a) Coronary Thrombosis	15 yrs
Due to (b) Hypertension	4 yrs
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W S Gerry M.D.
Address 6 W. Preston Date signed 2/5/45

VS 150

625470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310 Registered No. 625470

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 317 E. 24th st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 317 E. 24th st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME R. Willis Wright

3 (b) If veteran, name war: ~~Civil~~ None
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed or~~ divorced: Married
6 (b) Name of ~~husband or~~ wife: Blanche E. Wright
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2nd 1878

8. AGE: Years	Months	Days	If less than one day
66	6	0	hr. min.

9. Birthplace: Harford Co Md.
(Town, county, and state)
10. Usual Occupation: Retired Conductor
11. Industry or business: Pa R. R.

FATHER
12. Name: John C. Wright
13. Birthplace: Md.

MOTHER
14. Maiden Name: Clara Hamilton
15. Birthplace: Md.

16 (a) Informant: Lt. Willis Wright
(b) Address: 425 E. Cold Spring Lane

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/6/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~: Lorraine
Location: Balto. Co. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 127 St. Paul st

19 (a) FEB 5 - 1945 (Date rec'd by registrar) (b) Interment or Removal M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2nd 1945, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 1945, to Feb 2 1945, and that I last saw him alive on Feb 2 1945.

Immediate cause of death	Duration
Acut Cardiac Dil	1 day
Due to	
Due to Cardio renal dis. arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature C. N Meyer Jr
Address 1511 E 33rd Date signed 2/3/45

625471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

625471 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Linden & Madison Ave

(c) Hospital or institution: Maryland Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County Balto.

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 331 Carlisle Ave.

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME August Derwart (AUGUST DERWART)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. NONE

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced. WIDOWER

6 (b) Name of husband or wife ANNIE A DERWART

6 (c) If alive, give age * years

7. Birth date of deceased (mo., day, yr.) July 14, 1857

8. AGE: Years 87 Months 6 Days 17 If less than one day ..... hr. ..... min.

9. Birthplace Balto., Md.

(Town, county, and state)

10. Usual Occupation None

11. Industry or business none

FATHER

12. Name John Derwart

13. Birthplace Germany

MOTHER

14. Maiden Name Elizabeth Miller

15. Birthplace Germany

16 (a) Informant Margaret Stewart

(b) Address 331 N Carlisle Ave

17 (a) BURIAL (b) Date thereof FEB. 5. 1945

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory CATHEDRAL

Location

18 (a) Funeral director Chas. J. Evans Son

(b) Address 4 E N. Mt. Royal Ave

19 (a) FEB 5 - 1945 (b) Huntington Williams M.D.

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 1945 at 1:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1945 to Feb 1 1945 and that I last saw him alive on Feb 2 1945.

Immediate cause of death Generalized cachexia — Duration

Due to Carcinoma of bladder

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec 15, 1944

Major findings of operation: Carcinoma of bladder

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature H. H. McCormick M.D.

Address M. 2 H. Date signed Feb 2, 1945

625472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

625472
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 S. Washington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 S. Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Walczak Welsch

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-12-6186

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1904

8. AGE: Years 40 | Months 6 | Days | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Char Women

11. Industry or business

FATHER — 12. Name Michael Schultz
13. Birthplace Bohemia

MOTHER — 14. Maiden name Josephine Baburek
15. Birthplace Bohemia

16 (a) Informant Joseph Walczak
(b) Address 405 S. Washington St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Feb 6/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozakowski
(b) Address 1930 Eastern Ave

FEB 5 - 1945 (Date received) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1945, at 930 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1944 to Feb. 2 1945, and that I last saw her alive on Feb. 2 1945.

Immediate cause of death: Acute Cardiac Dilatation — Duration: 1 day

Due to: Hypertension — 1 yr.

Due to: Diabetes Mellitus — 1 yr.

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John V. Fitzpatrick M. D.
Address 1802 Eastern Ave Date signed 2-3-45

x Lazarbicki

G25473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47F

Registered No. G25473

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2022 Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Pushkin

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Israel
13. Birthplace Russia

MOTHER
14. Maiden Name Gussie
15. Birthplace Russia

16 (a) Informant Irvin Pushkin
(b) Address 2022 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnel St

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 FEB 5 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29th 1945, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1944, to Jan 29th 1945, and that I last saw him alive on Jan 29th 1945.

Immediate cause of death: Carcinoma - mediastinal & metastasis in the brain — Duration: 8-9 months

Due to:

Due to:

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation Aug. 17-1944

Major findings of operation: metastatic adeno-carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Pushkin M. D.

Address 2338 Eutaw Pl. Date signed 1-29-45

625474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

625474 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1307 OSTEND ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 OSTEND ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** WILLIAM BAUMAN.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-15-8723

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife ELIZABETH BAUMAN
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) MARCH 11 1875

8. AGE: Years	Months	Days	If less than one day
69	10	24	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation STRAW HAT BLOCKER
11. Industry or business MEN'S HATS INC.

FATHER
12. Name JOHN BAUMAN
13. Birthplace GERMANY

MOTHER
14. Maiden Name ANNA KOCH.
15. Birthplace NOT KNOWN.

16 (a) Informant MRS MARIE DE COURSEY
(b) Address 1307 OSTEND ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-7-45 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTO MD

18 (a) Funeral director Bernard C Hank
(b) Address 121 E West St

19 (a) FEB 5 - 1945 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 4 1945 at 345 A M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC 1944 to FEB 4 1945, and that I last saw h[illegible] alive on FEB 4 1945

Immediate cause of death	Duration
Cancerous Ulceration	2 mos
Due to Duodenal	
Due to Cardiac Insufficiency	2 Months
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Shepherd Evans M. D.
Address 1127 E Mt Royal Ave Date signed FEB 5 1945

625475 ✓ 625475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1190

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1136 Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Moe

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. ---

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1944

8. AGE: Years | Months 6 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Moe
13. Birthplace Norway

MOTHER
14. Maiden Name Alvida Jacobs
15. Birthplace Sayersville N.J.

16 (a) Informant Henry Moe
(b) Address 1136 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

19 (a) FEB 5 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3 1945, at 9.15 A M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Infantile Diarrhoea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Knight B. McNally M.D.
Medical Examiner.
Date signed 2/4/45

625476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

N 97

625476
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 941 Bennett Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 941 Bennett Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Burris

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Peters Burris
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mrs. Reva Minter
(b) Address 1813 Etting Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) FEB 5 - 1945 (Filed by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2, 1945, at 4:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-12-1944 to 2-2-1945 and that I last saw him alive on 2-2-1945

Immediate cause of death Arterio-sclerosis — Duration

Due to Senility

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell M. D.
Address 718 Dolphin St. Date signed 2-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully ... The correct age is especially important. Physicians: please write the ... of death clearly and legibly.

625177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

625177 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3031 Gwynns Falls Pkwy.

(c) Hospital or institution: Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County City of Balto.

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3031 Gwynns Falls Pkwy (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country No

3 (a) **FULL NAME** Dora Caroline Klank Mc Kericker

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband ~~or wife~~ Alex. J. McKericker

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 13, 1879

8. AGE: Years 65 Months 8 Days 20 If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER 12. Name George Klank

13. Birthplace Germany

MOTHER 14. Maiden Name Charlotte Fahrenholz

15. Birthplace Germany

16 (a) Informant Mrs. H. F. Elliott - Dtr-in-law)

(b) Address 4803 Keswick Rd, City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-(month) -(day) -45 (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Ave., City.

18 (a) Funeral director STEWART & MOWEN COMPANY

(b) Address (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

19 (a) ... (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

FEB 5 - 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 1945, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 4 1944, to Feb 3 1945, and that I last saw h[er] alive on Nov 5 1944.

Immediate cause of death	Duration
Acute Coronary Thrombosis	1 hr
Due to Arterio sclerotic Cardio vascular disease	4 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at ... M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? ... (Specify type of place)

(e) Means of injury —

23. Signature Francis W. Kluck M.D.

Address 715 Park Ave Date signed 2/5/45

625478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

625478 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Raynor Ave.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 460 Liberty Height
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Ida Bell Miller

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: none
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 10 1860

8. AGE: Years 84 | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace Martinsburg W. Va.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Henry Miller
13. Birthplace probably — Penna.

MOTHER
14. Maiden Name Margaret Lantz
15. Birthplace probably Lutersburg Md

16 (a) Informant Mrs Mabel Ackerson (niece)
(b) Address 2667 Pennsylvania Ave. Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 5 45 (month, day, year)
(c) Cemetery or crematory Greenmount Cemetery
Location Martinsburg W. Va.

18 (a) Funeral director Stewart & Mason Co.
(b) Address 1080 W Mulberry

19 (a) FEB 5 1945 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 1945, at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16 1945 to 2-2 1945 and that I last saw h.. alive on 2-2 1945.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Lobular pneumonia	
Due to —	
Other Conditions Pulmonary Edema (acute)	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ruth W. Anderson M. D.
Address Balto. General Hosp. Date signed 2-2-45

VS 150

625479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625479 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens & Caton Aves.

(c) Hospital or Institution St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 8 S Gilmor St. - 23 (If rural give location)

(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Ireland

3 (a) FULL NAME Mrs Margaret A Mc Gowan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John P

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1-96

8. AGE: Years 49 | Months 1 | Days 2. | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at home

FATHER 12. Name Daniel Horan

FATHER 13. Birthplace Ireland

MOTHER 14. Maiden Name Bridget Horan

MOTHER 15. Birthplace Ireland

16 (a) Informant Mr. John P. Mc Gowan

(b) Address 8 S. Gilmor Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem

Location 4300 Old Sled Road

18 (a) Funeral director John J Cowan & Son

(b) Address 9603 Hollins Street.

FEB 5 - 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3, 1945, at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27 1945 to 2/3 1945, and that I last saw he/r alive on 2/3 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Secondary Pneumonia	
Due to Chronic Heart failure due to Hypertension	
Other Conditions Cardio Vascular Disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William J. Bryne M.D.

Address St Agnes Hosp Date signed 2/3/45

HEALTH DEPARTMENT—CITY OF BALTIMORE

625480 CERTIFICATE OF DEATH 625480

1. PLACE OF DEATH 529 Hoffman 92D Registered No.

CITY OF BALTIMORE: (No. 529 W. Hoffman St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Howard Saunders

If U.S. Veteran specify WAR ...

(a) Residence: No. 529 Hoffman St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) July 20 1878

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
66	6	11	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. ✓

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Md

FATHER

13. NAME William Saunders

14. BIRTHPLACE (city or town) (State or country) Va.

MOTHER

15. MAIDEN NAME Jane Jones

16. BIRTHPLACE (city or town) (State or country) Baltimore Md

17. INFORMANT Jane Saunders

(Address) 529 Hoffman Street

18. BURIAL, CREMATION, OR REMOVAL

Place Mt Auburn Date 2/5 1945

19. UNDERTAKER Isaiah L Brown Son

(Address) 1540 Montgomery Street

20. FILED FEB 5 - 1945 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb 1 1945

22. I HEREBY CERTIFY, That I attended deceased from Jan 28 1945 to Feb 1 1945

I last saw h... alive on Jan 31 1945 Death is said to have occurred on the date stated above, at ... m.

The principal cause of death and related causes of importance were as follows:

Vascular Disease — Date of onset

Heart

Other contributory causes of importance:

Was an operation performed? No — Date of —

For what disease or injury? —

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Frank E. Wagner M. D.

(Address) 3027 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 3

X

625481 BALTIMORE CITY HEALTH DEPARTMENT X ✓ 625481

CERTIFICATE OF DEATH 106 C

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 2 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Crafton Pa.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 71 Warren St. (If rural, give location)
(e) Citizen of foreign country? — No (Yes or No)
If yes, name country

3 (a) FULL NAME George Edward Willson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-20-44

8. AGE: Years	Months	Days	If less than one day
1 yr.	—	13	— hr. — min.

9. Birthplace Penna. (Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Robert L. Wilson
13. Birthplace Penna.

MOTHER
14. Maiden Name Mary Supple
15. Birthplace Missouri

16 (a) Informant Mrs. Wilson
(b) Address c/o 3410 Rosedale Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/6/45 (month) (day) (year)
(c) Cemetery or crematory Wilkwood
Location Williamsport, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) FEB 3 1945 (b) Huntington Wilson, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-3-1945 at 6:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3 1945, to 2-3-1945 and that I last saw him alive on 2-3-1945

Immediate cause of death	Duration
Tracheo Bronchial Obstruction	
Due to Lobular Tracheo Bronchitis	
Due to	
Other Conditions None.	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Konstam L. Beyl M. D.
Address Mercy Hosp. Date signed 2/5/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45D

Registered No. 625182

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Denison St.
(c) Hospital or institution:
Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1658 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID ELMER BEEGLE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Separated

6 (b) Name of husband or wife Virginia Beegle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1877

8. AGE: Years	Months	Days	If less than one day
67	3	22	hr. min.

9. Birthplace Bedford Co., Pa.
(Town, county, and state)
10. Usual Occupation Druggist
11. Industry or business

FATHER
12. Name John H. Beegle
13. Birthplace Bedford Co., Pa.

MOTHER
14. Maiden Name Anna Bohn
15. Birthplace Bedford Co., Pa

16 (a) Informant Mrs. Burkart
(b) Address 1658 W. North Ave.

17 (a) Burial (b) Date thereof 2/6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 2-5-1945 (b) Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1945 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1945, to Feb 3 1945, and that I last saw him alive on Feb 3 1945

Immediate cause of death	Duration
Metastases in Brain	2
Due to Carcinoma of Left Supraclavicular	3
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. J. Tickner M. D.
Address 1101 N. Milton Date signed 2/3/45

VS 190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 (Registered No.)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5014 Ivanhoe Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5014 Ivanhoe Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS HAAS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Mollie E. Haas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1864

8. AGE: Years	Months	Days	If less than one day
80	7	26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Cabinet Maker Retired
11. Industry or business

FATHER
12. Name Ludwig Haas
13. Birthplace Germany

MOTHER
14. Maiden Name Lina unknown
15. Birthplace Germany

16 (a) Informant Miss Helen M. Haas
(b) Address 5014 Ivanhoe Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH Feb. 2, 1945, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-5 1944 to 2-2 1945
and that I last saw h/M alive on 2-2 1945

Immediate cause of death Atherosclerosis - Coronary Artery Disease - — Duration 2 days.
Due to Senile Arteriosclerosis - — Duration years -
Due to — Duration
Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify which)
(e) Means of injury

23. Signature H. Thomas Haas Jr
Address 527 Park Rd Signed 2/3/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. 6234

6234

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3801 Copley Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick W. Senning

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Helen B. Senning
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1888

8. AGE: Years	Months	Days	If less than one day
56	6	7	hr. min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Steamship Agent
11. Industry or business Dichman, Wright & Pugh

FATHER 12. Name George Senning
13. Birthplace Germany

MOTHER 14. Maiden Name Catherine Loos
15. Birthplace New Jersey

16 (a) Informant Mrs. Helen B. Senning
(b) Address 3801 Copley Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3, 1945, at 4:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4-45 19 , to 2-3-45 19 , and that I last saw him alive on 2-2-45 19 .

Immediate cause of death	Duration
Respiratory failure	
Due to Generalized Carcinomatosis	
Due to Metastatic melanosarcoma	
Other Conditions	

over

(Include pregnancy within 3 months of death)
Date of operation Jan. 12, 1945
Major findings of operation: Metastatic Melano-sarcoma
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. J. Brady M. D.
Address Md. Gen. Hosp. Date signed 2-3-45

FEB 5

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G25485

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1923 E. Lafayette Ave

(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) — 9

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1923 E. Lafayette Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Frederick C. Rohlfing

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-01-5748

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ruby E. Rohlfing

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) May 7-1883

8. AGE: Years	Months	Days	If less than one day
61	10	26	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Standard Oil Co

FATHER 12. Name Henry Rohlfing

13. Birthplace Md

MOTHER 14. Maiden Name Louise Schludebeg

15. Birthplace Md

16 (a) Informant Ruby E. Rohlfing

(b) Address 1923 E. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/45 (month) (day) (year)

(c) Cemetery or crematory Trinity

Location Baltimore Md

18 (a) Funeral director F. A. WIPPERT, Son

(b) Address 300 Eastern Ave

19 (a) (Date rec'd by registrar) FEB 6 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2nd 1945, at 10:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to Feb 2 1945 and that I last saw h[illegible] alive on Feb 2 1945.

Immediate cause of death	Duration
Coronary Thrombosis	3 Weeks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph Pokorny M.D.

Address 2200 E Madison St Date signed 2/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61 V

(Registrar's No.)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Baltimore General Hospital V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 465 S Kasouth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jane R. Lawson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married.

6 (b) Name of husband or wife William H. Lawson

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 11/20/1888

8. AGE: Years	Months	Days	If less than one day
56	2	15	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation HW

11. Industry or business

FATHER
12. Name Samuel Fountain
13. Birthplace Md

MOTHER
14. Maiden Name Mary E. Robertson
15. Birthplace Scotch Irish Canada

16 (a) Informant Wm. H. Lawson
(b) Address 46 S. Kasouth St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md

18 (a) Funeral director J. B. Hepburn & Son
(b) Address 300 Eutaw Place

19 (a) (Date received by registrar) FEB 7 (b) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-4 1945 at 3 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12-1945 to 2-4-1945, and that I last saw her alive on 2-4-1945

Immediate cause of death Respiratory failure — Duration

Due to Pulmonary Edema

Due to Coronary Heart Disease

Other Conditions Hypertension Diabetus Mellitus.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allen C. Wooden M. D.

Address W.B.M.H. Date signed 2-4-45

VS 150

94a

G25487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G25487 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Colon + Wilkins Ave.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. Ridgeway Rd (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mamie Hess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: late Frederick L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5, 1882

8. AGE: Years 62 | Months 1 | Days 30 | If less than one day: hr. 29 min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Ludwig
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Meeken
15. Birthplace Md

16 (a) Informant Mrs V. Kenneth Vansant
(b) Address Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Maryland

18 (a) Funeral director Haig H Wurtzler
(b) Address 4101 Edmondson Ave

19 (a) (Date received by registrar) (b)

FEB 5 - 1945

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/4 1945 at 845 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1945, to 2/4 1945, and that I last saw h.e.r. alive on 2/4 1945.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension arteriosclerotic Cardio vascular disease

Due to

Other Conditions Fracture distal third left femur + Complete left hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence February 2, 45 M
(c) Where did injury occur? Ridgeway Rd. Catonsville (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Elevator to fell to floor

23. Signature Lee A. Olwig de Chaumont M. D.
St Agnes Hospital
Date signed 2-4-45

Hastings [illegible] approves - Howard J. Mc Kenna, M.D.

625488 ✓ 625488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully completed. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave
(c) Hospital or institution: General German Aged Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christina Regina Wenige

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: late Charles A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1863

8. AGE: Years 81 | Months 11 | Days - | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Philip Hoepel
13. Birthplace Germany

MOTHER
14. Maiden Name Mary E. Meyers
15. Birthplace Germany

16 (a) Informant General German Aged Home
(b) Address 22 S. Athol Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-45 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Elliott City Md.

18 (a) Funeral director Harry A. Wilke
(b) Address 4101 Edmondson Ave

19 (a) (Date received by Registrar) FEB 5 (b) 1945

VS 150

MEDICAL CERTIFICATION 10.10

20. DATE OF DEATH Feb 3 1945, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1/45 19 to Feb. 3/45. and that I last saw h er alive on Feb. 2/45 19

Immediate cause of death	Duration
Broncho-Pneumonia	2 days.
Due to Fracture of head of Femur.	
Due to 6 days.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 28/4
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 1-29-45 at 7 M
(c) Where did injury occur? Gen German aged Home (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Slipped - fell & floor

23. Signature Henry Noe DeCandia M. D.
Address 933 Hanover Feb 3 1945

Approved: Hugh B. [illegible] Health Officer
Examiner

625489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64

625489 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2407 State Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas STRAN Mc Curley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19 1945

8. AGE: Years	Months	Days	If less than one day
0	0	17	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Lt. Stran Mc Curley
FATHER 13. Birthplace Balto Md

MOTHER 14. Maiden Name Elizabeth Arnold
MOTHER 15. Birthplace Balto Md

16 (a) Informant Hosp. Record
(b) Address

17 (a) Burial (b) Date thereof Feb 6 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Henry P. Haskins Sons Co
(b) Address Mc Culloh & Orchard Sts

19 (a) (Date rec'd by registrar) (b) (Registrar)

FEB 5 - 1945 Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5 1945, at 5:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3 1945, to 2-5 1945, and that I last saw him alive on 2-5 1945.

Immediate cause of death Respiratory failure — Duration

Due to Congenital malformation, possibly enlarged Thymus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Dr.
Address Md. Gen. Hospital Date signed 2-5-45

X

G25490

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

5 3 B

G25490 Registered No.

PRESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Eutaw Pl. & Brooks Lane.
(a) Baltimore City, Maryland
(b) Street address Esplanade Apts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Esplanade Apts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NENA HELLER SACHS.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Isaac Sachs.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5th. 1874.

8. AGE: Years	Months	Days	If less than one day
70	6	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Moritz Heller,
13. Birthplace Austria.

MOTHER
14. Maiden Name Annie Shakman,
15. Birthplace Austria.

16 (a) Informant Mr. Philip Sachs,
(b) Address 1200 Lexington Bldg.

17 (a) Burial (b) Date thereof 2/5/45.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore Hebrew
Location Baltimore, Md.

18 (a) Funeral director David Sonneborn & Son
(b) Address 1902 Eutaw Place.

19 (a) FEB 5 1945 Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3rd. 1945 at 7 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1944 to Feb 3 1945, and that I last saw ~~he~~ she alive on Feb 3 1945.

Immediate cause of death	Duration
Renal carcinomatosis	6 mos
Due to Carcinoma ureteris	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frederick Lacks M. D.
Address Temple Garden Apts. Date signed 2-4-45

X

625491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1108 Registered No. 625491

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 Beechfield av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 704 Beechfield av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Reichardt

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Margaret
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 11-1886
8. AGE: Years 58 59 | Months 5 | Days 23 | If less than one day hr. min.
9. Birthplace Germany (town, county and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name John. Reichardt
13. Birthplace Germany

MOTHER
14. Maiden name L. Eichenback
15. Birthplace Germany

16 (a) Informant Margaret Reichardt
(b) Address 704 Beechfield av
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 6-45 (month) (day) (year)
(c) Cemetery or crematory Memorial Park
Location Baltimore. Md.
18 (a) Funeral director Wm. H. Valentine
(b) Address 2326 Auburn Av
PEB 5 - 1945 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3- 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1945, to Feb 3 1945, and that I last saw alive on Feb 3 1945.

Immediate cause of death:	Duration
aortic fibrillation.	
Lobar Pneumonia.	7 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B S Emrich M.D. M. D.
Address 2324 Arunah Date signed 2/5/45

625192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

625192 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St. & Rutland Ave

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1637 N. Bentalou 25

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Julius Hvedberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12-1928

8. AGE: Years	Months	Days	If less than one day
16 17	8	27	hr. min.

9. Birthplace Balto

(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER

12. Name Carl Hvedberg

13. Birthplace Russia

MOTHER

14. Maiden Name Goldie Attman

15. Birthplace Russia

16 (a) Informant Carl Hvedberg

(b) Address 1637 N. Bentalou

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-45 (month) (day) (year)

(c) Cemetery or crematory Wisdom Mill Rd.

Location H.Y.M. & R.R. Assn.

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Balto. 25

19 (a) FEB 5 - 1945 (Date received by registrar) Huntington Willis (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1945, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4 1945, to Feb. 4, 1945, and that I last saw him alive on Feb. 4, 1945.

Immediate cause of death	Duration
Cardio-Respiratory failure	?
Due to Cardio decompensation myocardial failure	
Due to Rheumatic Heart Dis.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Stanley H. Hirsh, M.D.

Address Sinai Hospital Date signed 2/6/45

VS 150

625493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

625493 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4103 Ridgewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2425 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Jane Newman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Joseph F. Newman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5 - 1860

8. AGE: Years 84 | Months 2 | Days 3 2 8 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired Agent for

11. Industry or business Apparel House

FATHER
12. Name John House
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Jane Thorp
15. Birthplace Baltimore Md.

16 (a) Informant Miss Margaret Knighton
(b) Address 4202 Hereford Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 - 6 - 45 (month) (day) (year)
(c) Cemetery or crematory Louden Park Cem
Location Baltimore Md.

18 (a) Funeral director Emanuel C. Eyler
(b) Address 1600 W. North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 5 - 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1945 at 11-10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1945 to Feb 3 1945, and that I last saw h[illegible] alive on Feb 3 1945

Immediate cause of death Acute dilation of heart — 1 hour duration

Cardio vascular disease — about 6 mo.

Due to

Due to Advanced arteriosclerosis ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles S. Tubbs M. D.

Address 2220 Garrison Blvd Date signed

625494

625494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160A Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St & Fulton Ave. 1509

(c) Hospital or institution: Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 4 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4014 Fairfax Rd - 16
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Baby Boy Rosinsky (A)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1945

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation newborn

11. Industry or business

FATHER
12. Name Isadore Rosinsky
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Leah Charnock
15. Birthplace Baltimore, Md.

16 (a) Informant Leah Rosinsky

(b) Address 4014 Fairfax Rd #16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/45 (month) (day) (year)

(c) Cemetery or crematory Woodmen Circle

Location

18 (a) Funeral director Sol Levinson Bros

(b) Address 1124 W North Ave

19 (d) FEB 5 - 1945 (Date filed by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1945 at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 31 1945 to Feb. 4 1945 and that I last saw him alive on Feb. 4 1945.

Immediate cause of death	Duration
Pyaba	
Pulmonal hemorrhage	
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Isadore Rosinsky M.D.

Address 2307 Eutaw Pl. Date signed 2/6/45

VS 2

G25495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

831

G25495 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important, correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 723 West Bay Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 Riggs avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-05-1282

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Susie Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24, 1889

8. AGE: Years	Months	Days	If less than one day
55	1	11	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Robert W. Jones
13. Birthplace Va

MOTHER
14. Maiden Name Lucy Jackson
15. Birthplace Va

16 (a) Informant Susie Jones
(b) Address 1408 Riggs ave

17 (a) Burial (b) Date thereof 2-6-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. E. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (b) Registrar
(Date received by registrar)

FEB 5 - 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 1945 at 11 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, Apoplexy

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Louis A. Huston M.D.
Medical Examiner.
Date signed Feb 3rd 1945

Huntington Williams

625496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

193D

625496

Registered No.

IN. 90681

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1 18 days

(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1627 Lawrence St

(If rural give location)

(e) Citizen of foreign country? (~~Yes~~ No)

If yes, name country

3 (a) FULL NAME Robert Conway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May. 15th, 1887

8. AGE: Years 57 | Months 8m | Days 17 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Arthur Conway (D

13. Birthplace Va.

MOTHER

14. Maiden Name Hannah Wilson

15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 6-1945 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial

Location Arbutus

18 (a) Funeral director J. a Brooks

(b) Address 1463 N. Carey,

19 (a) (Date rec'd by registrar) FEB 5 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2nd 1945 19 , at At 5.10 A.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15 1944, to 2/2 1945, and that I last saw h in alive on 2/2 1945.

Immediate cause of death: Cardiac failure — Duration: 1 Week

Due to: Hypertensive Cardio-vascular disease — Duration: 1 / ?

Due to — Duration:

Other Conditions Gen. Arteriosclerosis Early Gangrene rt. leg — Duration: ? 1 week

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Wm Kenneth Smith M.D.

Address Balt. City Hosp Date signed 2/2/45

625497

625497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

330 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 Westwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) ~~Town~~, Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1721~~ Same
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Scott

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	child

6 (b) Name of husband or wife Joyce Scott
6 (c) If alive, give age 3 years

7. Birth date of deceased (mo., day, yr.) 1/8/45

8. AGE: Years	Months	Days	If less than one day
		21/26	hr. min.

9. Birthplace Balto Md
(Town, county, and State)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Joyce Scott
15. Birthplace md.

16 (a) Informant William Hazelton
(b) Address 1721 Westwood ave

17 (a) Burial (b) Date thereof Feb 6 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Va Brooks
(b) Address 1123 N. Carey St

19 (a) (b) FEB 5 - 1945
(Date rec'd by registrar) Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/4/1945, at 7.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8/1945 to 2/4/1945, and that I last saw h alive on 1/21/1945.

Immediate cause of death Bronchopneumonia — Duration 4 days

Due to Softening of — 10 days

Due to Bronchitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Hopkins Bowley M.D.
Address 1721 N Carrollton Date signed 2/5/45

625498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49D

Registered No. 625498

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3221 Avon Ave.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3221 Avon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HATTIE M. DEMPSTER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife ---
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1867

8. AGE: Years	Months	Days	If less than one day
77	6	21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name George E. Dempster
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Bull
15. Birthplace Harford Co., Md.

16 (a) Informant Miss Mary Dempster
(b) Address 3221 Avon Ave.

17 (a) Burial (b) Date thereof 2/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

FEB 5 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1945, at 1 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943 to Feb 3 1945 and that I last saw h[illegible] alive on Feb 2 1945.

Immediate cause of death	Duration
Carcinoma - vulva	
Duration - recurrence with rapid & wide spread Abdominal involvement.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Oct 13, 1943

Major findings of operation: Carcinoma of vulva

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carroll Packard M. D.
Address 2925 N Charles St Date signed Feb 5 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

G25499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G25499 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 297 S. Pulaski St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 297 S. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Frances Stengler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife John P. Stengler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1st, 1865

8. AGE: Years 79 | Months 3 | Days - | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name James Cofran
13. Birthplace England

MOTHER
14. Maiden Name Mary V. Brown
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Philip Stengler
(b) Address 3015 Northway Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5th, 1945 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

FEB 5 - 1945

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1st 1945 at 11.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to Feb 1 1945 and that I last saw her alive on Jan 31 1945

Immediate cause of death: H. pertensive - arteriosclerotic Cardio - vascular disease — Duration: 2 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Callens M. D.
Address 3321 Frederick Ave Date signed

X 2-2-45

G25500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1862

G25500 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 Warner —
(c) Hospital or institution:
21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore —
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 Warner — —
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Holmes

3 (b) If veteran, name war — 1917
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Alice Holmes
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Aug 22 1887

8. AGE: Years 57 | Months 5 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore — Md —
(Town, county, and state)

10. Usual Occupation Hauler

11. Industry or business Business

FATHER 12. Name Henry Holmes

13. Birthplace Baltimore — Md

MOTHER 14. Maiden Name Mary Harris

15. Birthplace Virginia

16 (a) Informant Alice Holmes
(b) Address 1014 Warner

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/45 (month) (day) (year)

(c) Cemetery or crematory Baltimore National
Location Balto City

18 (a) Funeral director Sarah L. Brown Mrs
(b) Address 107 W Montgomery St

19 (a) FEB 5 1945 (Date received by registrar) (b) Huntington Hill Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 31 1945, at 7.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec - 23 1944 to Jan 31 1945, and that I last saw him alive on Jan 31 1945.

Immediate cause of death Acute Bronchopneumonia — Duration 10 D

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accidental
(b) Date of occurrence Dec - 23 - 44 at 5 P.M
(c) Where did injury occur? (City or town) Balto (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Coal yard — While at work? Yes
(Specify type of place)
(e) Means of injury Fell off truck

23. Signature [illegible] Hauler
Address 1111 W Lee. Date signed 2/1/45

Witness: Robert L. Taylor M.D.

625501

TN. 9120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625501

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 E. Ware St
(If rural give location)
(e) Citizen of foreign country? (Yes) No)
If yes, name country

3 (a) FULL NAME Henry Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1882

8. AGE: Years 62 | Months 11 | Days 10 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Bob Johnson
13. Birthplace Va.

MOTHER
14. Maiden Name Alice Moody
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof 2 6 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. R. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

(Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2nd, 1945 19 at 3.30 A.M at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/24 1944 to 2/2 1945, and that I last saw him alive on 2/2 1945.

Immediate cause of death: Cardiac failure — Duration 1 week

Due to: Luetic heart disease — Duration ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Kenneth Smith M. D.

Address Balt. City Hosp. Date signed 2/2/45

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25502

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 33B

Registered No. G25502

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not use abbreviations. If the exact date of birth is unknown, the correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 650 George St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 650 George St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosie Diggs
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Married

6 (b) Name of husband or wife Charles Diggs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years	Months	Days	If less than one day
39			hr. min.

9. Birthplace Westminster Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Russ Cooper
13. Birthplace Westminster, Md

MOTHER
14. Maiden Name Shane
15. Birthplace Westminster, Md

16 (a) Informant Mr Charles Diggs
(b) Address 650 George St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Feb 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

FEB 5 - 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/1/45 19 8 a.t. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/8/45 19 2/31/45 and that I last saw h[illegible] alive on 2/30/45

Immediate cause of death Uremic Nephritis (a) 4 days

Due to Pulmonary Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Ellen M. D.
Address [illegible] Date signed 2/4/45

X

G25503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 131a

G25503

YA-91775

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 Etting Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife Louise (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 8, 1877

8. AGE: Years	Months	Days	If less than one day
67	3	24	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Abraham
13. Birthplace ?

MOTHER
14. Maiden Name Jennie ?
15. Birthplace ?

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 6 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) FEB 5 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2, 1945 at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24, 1945 to Feb. 2, 1945 and that I last saw h im alive on Feb. 2, 1945.

Immediate cause of death coronary occlusion — Duration 7

Due to

Due to

Other Conditions chr. passive congestion; chr. glomerulonephritis; generalized arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. E. Perry J. M. D.
Address City Hosp. Date signed 2-6-45

G25504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G25504

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Died
(a) Baltimore City, Maryland
(b) Street address 4213 Kenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 4213 Kenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice M. Countess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1881

8. AGE: Years	Months	Days	If less than one day
63	1	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business F. W. Rice Co.

FATHER
12. Name James C. Countess
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Aline M. McDonald
15. Birthplace New York

16 (a) Informant Miss Mary Countess
(b) Address 4213 Kenwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Chas. J. Egan & Son Inc.
(b) Address 118 W. Mt Royal Ave

FEB 5 - 1945 (Date rec'd by registrar) (b) Transcription Clerk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2 19 45, at 7.20 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 2/2/45

VS 151

G25505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310 Registered No. G25505

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 E. Biddle street
(c) Hospital or institution: 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 E. Biddle
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME DANIEL A. LORDEN

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Married

6 (b) Name of husband or wife Susan A. Lorden
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1861

8. AGE: Years	Months	Days	If less than one day
83	2	12	hr. min.

9. Birthplace Baltimore Co. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Lorden
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Scott
15. Birthplace Ireland

16 (a) Informant Miss Sue Lorden
(b) Address 608 E. Biddle street

17 (a) Burial (b) Date thereof 2/6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Govans

18 (a) Funeral director Chas. J. Evans & Son Inc.
(b) Address 118 W Mt. Royal Ave

19 (a) FEB 5 1945 (b) Twenties for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1945, at M

21. I certify that death occurred on the date above stated, that I attended deceased from May 1941 to Feb 2 1945 and that I last saw him alive on Feb 1 1945

Immediate cause of death	Duration
Myocardial degeneration	4 yrs
with decompensation	
Due to marked secondary anemia	3 yrs
Due to Chr Nephritis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature William L Straight M.D.
Address 10 E Biddle Date signed 2/5/45

G25506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G25506

Registered No.

MARON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4267 Sheldon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 4267 Sheldon Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Dill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grace Dill

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2-1872

8. AGE: Years 72 | Months 11 | Days - | If less than one day hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Supervisor U.S. Mailmen

11. Industry or business: U.S Post Office

FATHER
12. Name: George E. Dill
13. Birthplace: Friendship Md

MOTHER
14. Maiden Name: Kunegunda Shipley
15. Birthplace: Germany

16 (a) Informant: Mrs Grace Dill
(b) Address 4267 Sheldon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 6-45 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location Frederick Rd Balto Md

18 (a) Funeral director: Milton Schilling
(b) Address 3914 Hanover St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

FEB 5 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2nd 1945 at 5 P M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1944 to Feb 2 1945.
and that I last saw h[illegible] alive on Feb 2 1945

Immediate cause of death: Cardiac Decompensation

Due to: Generalized Arteriosclerosis

Due to:

Other Conditions: Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration
7
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Laurel Lyon M.D.
Address 1 Hall Court Date signed 2/3/45

95C

G25507 | BALTIMORE CITY HEALTH DEPARTMENT | G25507

CERTIFICATE OF DEATH 470 | Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Church Home & Hospital
(c) Hospital or institution: Broadway
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Dundalk, P.O. (If outside city or town limits, write RURAL and give town)
(d) Street No. 721 North Point Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES TERRY

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-4500

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	A.	

6 (b) Name of husband or wife Anna Noel Terry
Katie Masterson (dec.) (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11 - 1881

8. AGE: Years	Months	Days	If less than one day
63	67	32	22 hr. min.

9. Birthplace Tennessee (Town, county, and state)
10. Usual Occupation Pipe Fitter
11. Industry or business Stan. Oil Co.

FATHER
12. Name Zenbenyon
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Mrs. Anna Terry
(b) Address 721 North Pt. Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 7-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd.

18 (a) Funeral director John J. Connolly
(b) Address 418 Eastern Ave. Essex

19 (a) FEB 5 1945 (Date rec'd by registrar) Hunting for Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1945, at 6.38 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to Feb 3 1945 and that I last saw him alive on Feb 3 1945

Immediate cause of death: Empyema, right chest — Duration 2 mos
Due to Carcinoma of Rt Lung & Ribs — 1 yr
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as stated above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Vernon F. Norwood M. D.
Address Church Home & Hospital Date signed 2-4-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FOR B...DING

625508

342398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A.
(c) City or town ANNAPOLIS (If outside city or town limits, write RURAL and give town)
(d) Street No. 54 Collage Creek Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hilda Hebron

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	black	?

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-22-04

8. AGE: Years	Months	Days	If less than one day
40	3	11	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Richard Brown
13. Birthplace Md

MOTHER
14. Maiden Name Perdella Parker
15. Birthplace Md

16 (a) Informant record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 8 1945 (month) (day) (year)
(c) Cemetery or crematory Brown Hill
Location Annapolis
18 (a) Funeral director J. B. Johnson
(b) Address Annapolis
19 (a) FEB 5 1945 (Date received by local registrar) (b) Huntington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1945 at 10:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28- 1945 to 2-3 1945 and that I last saw her alive on 2-3- 1945.

	Duration
Immediate cause of death: Respiratory failure	15 min.
Due to: Intoxication due to Sulfathiazole	7 days
Due to: Hepatitis Nephritis due to (1)	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature William J. Dixon
Address Johns Hopkins Hosp Date signed 2/4/45

VS 150

625509

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93a

Registered No. 625509

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d. or a
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 E. Biddle Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME (Verma Raye Coyle) Verma Raye Stonehouse

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years 34 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER 12. Name.....
13. Birthplace

MOTHER 14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory.....
Location JOHN HOPKINS MEDICAL SCHOOL FEB 1 1945

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 (a) FEB 5 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

2488

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12, 1945, at ..... M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxic Hypercondition

.....

.....

Due to.....

.....

Other Conditions.....

.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Packer M.D.
Medical Examiner.
Date signed Jan 31 1945

X

625510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625510 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Division St.
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2033 Druid Hillave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Gustine Berry

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	colored	married

6 (b) Name of husband or wife Wm T. Berry
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Sept 30. 1869

8. AGE: Years	Months	Days	If less than one day
75	4	3	hr. min.

9. Birthplace Phoenix, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Williams Chatman
13. Birthplace Phoenix, Md.

MOTHER
14. Maiden Name Mary Edwards
15. Birthplace Phoenix, Md.

16 (a) Informant Mrs Aylday Butler
(b) Address 2033 Druid Hill ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Wm. J. Chatman Jr
(b) Address 6009 Prescott ave.

19 (a) FEB 5 1945 (Registrar's signature) Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1945, at 4 15/A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 26 1944, to Feb. 3 1945, and that I last saw her alive on Feb. 3, 1945.

	Duration
Immediate cause of death hypertension pneumonia	24 hrs.
Due to cerebral hemorrhage	5 days
Due to hypertensive cardio-vascular disease	18 mos
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James D. Carr M. D.
Address 515 Park Pl. Date signed 2.5.45

G25511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No. G25511

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 742 Bradley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wyland Dodson Lyles

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 17, 1930

8. AGE: Years 14 | Months 10 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation School boy
11. Industry or business

FATHER
12. Name Milton Lyles
13. Birthplace Maryland

MOTHER
14. Maiden Name Effie Lyles
15. Birthplace Maryland

16 (a) Informant Milton Lyles
(b) Address 742 Bradley St.

17 (a) Burial (b) Date thereof 2-7-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cooksville.
Location Cooksville, Md.

18 (a) Funeral director C. R. Lawson
(b) Address 802 Madison Ave.

19 (a) FEB 5 - 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1, 1945 at 1:30 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intra cranial Hemorrhage spontaneous
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Graham M.D.
Medical Examiner.
Date signed Feb. 1 1945

G25512

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G25512 Registered No. 1579

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 Gilmor Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Mo - 3 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - 17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Gilmor Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jay Andrew Montgomery
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Child
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1/1/45
8. AGE: Years | Months 1 | Days 3 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER: 12. Name Howard Montgomery; 13. Birthplace Baltimore Md
MOTHER: 14. Maiden Name Bertha Ray; 15. Birthplace Baltimore Md

16 (a) Informant Howard Montgomery
(b) Address 1613 N. Gilmor St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 6-1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn
18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey St
19 (a) FEB 5 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/4 1945, at 11:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1945 to 2/4 1945, and that I last saw h[illegible] alive on 2/4 1945

Immediate cause of death: Prematurity — | Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Carson C. Johnson M. D.
Address 1802 Penna Date signed 2/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G25513

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Carolide St.

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)

(d) Street No. 147 N. Streeper St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Agnes Borichetto

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) ~~Single~~, married, ~~widowed, or divorced~~.

6 (b) Name of husband or wife Paul W. Borichetto

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8 - 1894

8. AGE: Years 50 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Peter Hoff

13. Birthplace Germany

MOTHER

14. Maiden Name Unknown

15. Birthplace Germany

16 (a) Informant Husband Paul W. Borichetto

(b) Address 147 N. Streeper St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7th 45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Frederick Road

18 (a) Funeral director Frank V. Pipitone

(b) Address 2818 E. Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 5 - 1945

Huntington Wire

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1945, at 1 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1944, to Feb 3 1945, and that I last saw h[illegible] alive on Feb 3 1945.

Immediate cause of death (RENAL FAILURE

Due to CARCINOMA OF URINARY BLADDER

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct. 7, 1944

Major findings of operation: Invasion of bladder wall

of autopsy: Tumor Mass

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature James J. Pratt, J. M.D.

Address St. Joseph's Hospital Date signed 2/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

625514

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5507 Bosworth Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5507 Bosworth Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pauline Askins Wilkens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William H. Wilkens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 6, 1882

8. AGE: Years	Months	Days	If less than one day
62	5	28	hr. min.

9. Birthplace Port Conway, Va. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William C. Askins
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Burrows
15. Birthplace Virginia

16 (a) Informant Mrs. Wm. L. Frasch
(b) Address 5507 Bosworth Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 7, 1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miller Lamoreau
(b) Address 4520 Liberty Heights Ave.

19 (a) 2-5-1945 (Date rec'd by registrar) (b) Hunter for Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1945, at 8.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15' 19XX to Feb 4 1945, and that I last saw h er alive on Feb 2 1945.

Immediate cause of death Carcinoma of Liver — Duration 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E William Frey
Address 1928 Pennsylvania Ave. Date signed 2/5/45

G25515 BALTIMORE CITY HEALTH DEPARTMENT G25515

CERTIFICATE OF DEATH V/107

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Eaton avenue
(c) Hospital or institution: Jewish Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 0 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County /
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 N. Collington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas C. Valanovsky

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary E. Valanovsky
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1879

8. AGE: Years	Months	Days	If less than one day
65	1	10	hr. min.

9. Birthplace Bohemia (Town, county, and state)
10. Usual Occupation
11. Industry or business Hardware Business

FATHER
12. Name Charles Valanovsky
13. Birthplace Bohemia

MOTHER
14. Maiden Name Not Known
15. Birthplace Bohemia

16 (a) Informant Jewish Memorial Hospital
(b) Address 1000 Eaton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balt Md

18 (a) Funeral director Hench Brochhorst
(b) Address 1004 N. Eutaw St

19 (a) (Signature of) (b) Livingston Williams registrar
(Delivered by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2, 1945, at 8:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1944 to 2/2 1945 and that I last saw h[illegible] alive on 2/2 1945.

Immediate cause of death Respiratory failure — Duration

Due to Bronchopneumonia — Duration

Due to Parkinsonism — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Bryan M. D.
Address 1004 N. Eutaw St Date signed 2/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

MARG[illegible] RESERVED FOR BINDING

MARG... RESERVED FOR B...DING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B 625516 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton St.
(c) Hospital or institution: Ashbuton Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-8
(e) Length of stay in Baltimore (yrs., mos., or days) 62-7-12

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2108 Allendale Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Agnes Schiaffino

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1882

8. AGE: Years	Months	Days	If less than one day
62	7.	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

MOTHER | FATHER
12. Name Giovanni Schiaffino
13. Birthplace Italy
14. Maiden Name Paoline Mortola
15. Birthplace Italy

16 (a) Informant Mr. James H. Schiaffino
(b) Address 46 Melvin Ave. Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Baltimore, Md.

18 (a) Funeral director N. W. Meadows
(b) Address 805 North Calvert st.

19 (a) FEB 7 1945 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1945, 2.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/26 1943 to 2/4 1945 and that I last saw h[illegible] alive on 2/1 1945.

Immediate cause of death: Carcinoma of the Urinary Bladder — Duration 18 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert A. Reiter, M.D.
Address 340 W. Madison St. Date signed 2/5/45

X

G25517

BALTIMORE CITY HEALTH DEPARTMENT ✓ G25517
CERTIFICATE OF DEATH 93D
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 Little Sisters (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Kennedy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/18/55

8. AGE: Years	Months	Days	If less than one day
89	4		hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John Kennedy
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Farlon
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto, Md

18 (a) Funeral director Flynn & Fleming
(b) Address 1421 Light St

19 (a) (b) Rec'd by registrar Lington Williams, M.D. Registrar

FEB 6 1945
VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1945, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1945, to Feb 5 1945, and that I last saw her alive on Feb 5 1945.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	8 yrs
Due to Arteriosclerosis	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C Gill Hall M. D.
Address 1631 2 North Ave Date signed Feb 5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

625518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 625518

95 Registered No.

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33[illegible] + Calvert

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 Day

(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Harford

(c) City or town Bel Air (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Florence Jane GREER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. divorced

6 (b) Name of husband or wife Nathan Greer

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 3-11-1872

8. AGE: Years 72 | Months 10 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Mr. James Strum

13. Birthplace ?

MOTHER 14. Maiden Name ?

15. Birthplace

16 (a) Informant Brother in law

(b) Address Bel Air, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 8/45 (month) (day) (year)

(c) Cemetery or crematory Forestmount

Location Baltimore Md

18 (a) Funeral director Dean & Foster

(b) Address Bel Air Md

19 (a) FEB 6 1945 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1945 at 6:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 1945 to 2-5 1945 and that I last saw her alive on 2-5 1945.

Immediate cause of death	Duration
Cardio-Respiratory failure	
Due to Pulmonary Edema	
Due to Cardiac Decompensation	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Geo. W. Livingstone Jr. M. D.

Address 332 E. University Pkwy. Date signed 2/6/45

Huntington Williams, M.D.

VS 150

X

G25519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G25519

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive and 31st

(c) Hospital or institution:

US Marine Hospital, Balto. Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo27da

(e) Length of stay in Baltimore (yrs., mos., or days) 1mo27da

2. USUAL RESIDENCE OF DECEASED:

(a) State Minn. (b) County

(c) City or town Minneapolis
(if outside city or town limits, write RURAL and give town)

(d) Street No. 3208 37th Ave.,
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GORDON NICHOLES HENDERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Sylvia Olsen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/1/13

8. AGE: Years	Months	Days	If less than one day
31	4 5	4	hr. min. 1611

9. Birthplace Minneapolis, Minnesota
(Town, county, and state)

10. Usual Occupation Steward-Merchant Marine

11. Industry or business

FATHER
12. Name William Henderson
13. Birthplace Canada

MOTHER
14. Maiden Name Henrietta Hager
15. Birthplace Minn.

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-45 (month) (day) (year)

(c) Cemetery or crematory
Location Minneapolis Minn

18 (a) Funeral director A. Lee Alder
(b) Address 4677 York Rd.

19 (a) FEB 6 1945 (Date received by Registrar) (b) Huntington Williams, M.D. (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1945 10:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 9, 1944 to Feb. 5, 1945 and that I last saw h. im alive on Feb. 5, 1945.

Immediate cause of death: Embrynol carcinoma of right testicle with

Due to massive retroperitoneal metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: As above

Duration
3 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Benjamin D Jones M. D.

Address US Marine Hosp Baltimore Maryland Date signed 2/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Your correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940

✓ G25520

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3012 Clifton Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3012 Clifton Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME James W. Collins

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband~~ or wife Mary E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21st 1870

8. AGE: Years	Months	Days	If less than one day
74	5	13	hr. min.

9. Birthplace Balto Md

(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Builder

FATHER

12. Name Jeremiah Collins

13. Birthplace Balto. Md.

MOTHER

14. Maiden Name Charlotte (Unknown)

15. Birthplace Balto. Md.

16 (a) Informant Howard J. Collins

(b) Address 3221 Presstman St

17 (a) Burial (b) Date thereof 2/7/45

(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Lorraine

Location Balto Md.

18 (a) Funeral director William Cook Inc

(b) Address 127 St. Paul St

19 (a) FEB 6 1945 (b) Clinton Williams, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4th 1945, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from January 26 1945 to February 4 1945, and that I last saw ~~him~~ her alive on 2-4 1945.

Immediate cause of death	Duration
Coronary Thrombosis	10 days
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Leon Ashman M. D.

Address 1201 Poplar Grove St Date signed 2-5-45

VS 150

625521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

625521 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 216 E. 22nd St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 216 E. 22nd St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary N. Griffith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband Miram Griffith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12th 1871

8. AGE: Years: 73 | Months: 10 | Days: 21 | If less than one day: hr. min.

9. Birthplace Minn. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name James Boland
13. Birthplace N.Y.

MOTHER
14. Maiden Name Mary (Unknown)
15. Birthplace N.Y.

16 (a) Informant Jean G. Platt
(b) Address 216 E. 22nd St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/7/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (Date filed by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3rd 1945, at 1 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942, to Feb 3rd 1945 and that I last saw h[illegible] alive on Feb 2nd 1945

Immediate cause of death	Duration
Acute Cardiac Dilatation	3 days
Due to Cardiac Vascular Disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 2687 Wheeler Ave Date signed Feb 4/45

G25522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G40524 Registered No.

MARG. RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4601 Valley View av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4601 Valley View av (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Mary Lampe

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Harry Lampe
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 10 1883
8. AGE: Years 61 | Months 11 | Days 23 | If less than one day hr. min.
9. Birthplace: Ohio (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: at Home

FATHER
12. Name: Henry Young
13. Birthplace: unknown

MOTHER
14. Maiden Name: Anne Whitmore
15. Birthplace: Pa.

16 (a) Informant: Harry Lampe
(b) Address: 4601 Valley View
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/45 (month) (day) (year)
(c) Cemetery or crematory U. S. National
Location: Balto. Md.
18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul st.
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150
FEB 6 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3. 1945, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26 1945 to Feb. 3 1945, and that I last saw h. alive on Feb 3 1945.

	Duration
Immediate cause of death: Acute Dilation Heart	3 hrs
Acute myocarditis	9d
Due to: Lobar Pneumonia	9d.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(c) Means of injury
23. Signature: F F A Stevens M. D.
Address 7878 Harford Rd Date signed 2-5-45

625523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 5523

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2803 Garrison Blvd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2 Guernsey Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Jeffers

3 (b) If veteran, name war —

3 (c) Social Security Account No. none.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Separated

6 (b) Name of husband or wife Harry J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 8 1874

8. AGE: Years	Months	Days	If less than one day
About 71			hr. min.

9. Birthplace Hagerstown Md (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER

12. Name Martin Hotel

13. Birthplace Germany

MOTHER

14. Maiden Name Rosina Bickmon

15. Birthplace Germany

16 (a) Informant Mrs. George Mitchell

(b) Address 4202 Guernsey

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/45 (month) (day) (year)

(c) Cemetery or crematory Rose Hill

Location Hagerstown Md

18 (a) Funeral director Mathews Funeral Home

(b) Address 1211 E Fayette St

19 (a) FEB 6 1945 (Date rec'd by registrar) (b) Hunter's Mill Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1945, at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1944 to Feb 3 1945 and that I last saw h. alive on Jan 27 1945

Immediate cause of death Coronary Thrombosis — Duration Immediate

Due to Arteriosclerosis — Duration Indefinite

Due to — Duration

Other Conditions Diverticulosis of Large Bowel — Duration Dec 30 44 - Jan 27

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence —

(c) Where did injury occur? — at — M (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury —

23. Signature Nathaniel M Beck

Address 2727 N Charles St Date signed Feb 5-45

JOHN W. SCHAFFER

625524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D ✓ Registered No. 625524

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3624 Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 Weldon Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN W. SHAEFER

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-07-2421

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary E. Schaffer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14-1866

8. AGE: Years 78 | Months 1 | Days 19 | If less than one day hr. min.

9. Birthplace Carroll Co. Maryland (Town, county and state)

10. Usual Occupation Watchman

11. Industry or business Lumber Yard & Storage Co.

FATHER
12. Name Louis Schaffer
13. Birthplace Maryland

MOTHER
14. Maiden Name Susanna Stull
15. Birthplace Maryland

16 (a) Informant Miss Gladys E. Schaffer
(b) Address 1310 Weldon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 6-1945 (month) (day) (year)

(c) Cemetery or crematory M. Payne
Location Arcadia, Carroll Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) FEB 6 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3, 1945, at 6:20 A.M.

21. I certify that I took charge of the remains described above, held an ..... thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ..... death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. (Medical Examiner)
Date signed February 3, 1945

VS 151

625525

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

830 ✓ 625525 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3403 Richmond Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3403 Richmond Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marcia Lena Heusler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~: Howard Heusler | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20 1896

8. AGE: Years	Months	Days	If less than one day
48	4	15	hr. min.

9. Birthplace Howard Co. Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business At Home

FATHER
12. Name William Thompson
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Magcia Lena (Unknown)
15. Birthplace Howard Co. Md.

16 (a) Informant Maida Turner
(b) Address 4734 Shamrock Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Cathedral Mt
Location Baltimore Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul st

19 (a) [illegible] (Date received by Registrar) Lon Williams, M.D. Registrar

FEB

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5th 1945, at 8 15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to Feb 5 1945. and that I last saw her alive on Feb 5 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage.	1 hour
Due to Arterio Sclerosis	5 yrs
Due to Highblood pressure	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. H. C. Zimmerman M. D.
Address 9858 Harford Rd Date signed 2/5/45

X

625526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1602 ~~625526~~

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2732 Mar Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy. Hoffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			16 hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Karl Hoffman
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mary Jarboe
15. Birthplace Maryland

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Md

18 (a) Funeral director Mallon & Son
(b) Address 1210 E Fort Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150 FEB 6 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1945, at 730 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on Feb 2 1945

Immediate cause of death Atelectasis Council
Hemorrhage
Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Burch M. D.
Address University Hosp Date signed 2-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the causes of death clearly and legibly

625527

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

53

625527
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1308 S. Carey st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~2~~ 1308 S. Carey st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin W. Rusk

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Fanny E. Rusk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2nd 1850

8. AGE: Years	Months	Days	If less than one day
95	1	2	...hr. ...min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Butcher

FATHER
12. Name (Unknown) Rusk
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Louis E. Rusk
(b) Address 1308 S. Carey st

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/7/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Jr Co
(b) Address 1217 St. Paul st

19 (a) FEB 6 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4th 1945, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 1944 to Feb 3 1945; and that I last saw h... alive on Feb 3 1945.

Immediate cause of death	Duration
Thrombosis	10 days
Due to Cancer of Face	1 year
Due to Toxic absorption of Cancer,	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Shipley Adams M. D.
Address Date signed 2/6/45

VS 150

For H. B. McNally, by Hunter L. Maddox, M.D.

625528

625528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1252

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts. 1252
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 75 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3516 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Mrs. Elizabeth Frederick

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles H. Frederick
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1869

8. AGE: Years	Months	Days	If less than one day
75	4	3	-- hr. -- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Conrad Schneider
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Seeberger
15. Birthplace Germany

16 (a) Informant Mrs. Chester H. Stone
(b) Address 3516 N. Calvert Street

17 (a) Burial (b) Date thereof 2/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) FEB 6 - 1945 Huntington Hollins, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/4 1945, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1944, to 2/4 1945, and that I last saw her alive on 2/4 1945.

Immediate cause of death Coronary Thrombosis
Due to Hemorrhage into Colon
Due to Diffuse Sarcoma of Colon
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard C. Wallace M.D.
M. D.
Address 1400 N. Calvert St Date signed 2/4/45

VS 199

G25529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G25529 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1324 N. Bond
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 N. Bond (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie B. Henson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Elijah Henson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 2 - 1869

8. AGE: Years 75 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Samuel Cornish
13. Birthplace Md

MOTHER
14. Maiden Name Dorthy —
15. Birthplace Md

16 (a) Informant Sadie Shannon
(b) Address 1324 N. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 6 - 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director James Watkins
(b) Address 142 W. Fayette St

19 (a) FEB 6 1945 (Date received by Registrar) (b) Washington Nationals, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1945 at 6 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1945 to Feb 3 1945; and that I last saw her alive on Feb 1 1945.

Immediate cause of death: Congestive Heart Failure

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: Month

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. K. Edson M. D.
Address 222 N. Carolina Signed

Feb 5 45

625530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 625530

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1838 N. Caroline St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1838 N. Caroline St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Margaret Warwick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 1897

8. AGE: Years	Months	Days	If less than one day
47	6	30 29	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Robert J. Warwick
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Hall
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Margaret Warwick
(b) Address 1838 N. Caroline St.

17 (a) Buried (b) Date thereof 2 7 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md.

18 (a) Funeral director Martin Sypert & Sons
(b) Address 182 W. North Ave.

19 (a) (Date filed by registrar) (b) Huntington Williams, M.D.

VS 15a 5-1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 18, 1943, to Feb. 3, 1945, and that I last saw h.. alive on Feb. 2, 1945.

Immediate cause of death	Duration
Apoplexy	11 days
Due to Hypertension Heart disease	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. B. Sypert M. D.
Address 2807 Harford Rd. Date signed 2-5-45

6c5531 BALTIMORE CITY HEALTH DEPARTMENT 13B Ref. 6c5531

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Laynor
(c) Hospital or institution: West Baltimore General Hosp 2-5-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 Linden Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Merrill E Curtis

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-9524

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 4 1899

8. AGE: Years 45 | Months 3 | Days - | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER 12. Name Homer Curtis

FATHER 13. Birthplace Md

MOTHER 14. Maiden Name Hattie Colens

MOTHER 15. Birthplace Md

16 (a) Informant Wife

(b) Address 1359 Linden Blvd

17 (a) Medical Facility thereof (burial, cremation or removal) Feb 8 (month) (day) (year)

(c) Cemetery or crematory Medow Ridge

Location Liberty Road

18 (a) Funeral director Edward Fowler

(b) Address 1359 Linden Blvd

19 (a) FEB 6 1945 (Date rec'd by Registrar) Huntington, Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1945 at 10:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Feb 4 1945 and that I last saw him alive on Feb 4 1945.

Immediate cause of death Cardiac Dilation failure — Duration

Due to Rheumatic Cardiac valvular disease

Due to Mitral insufficiency with Auricular fibrillation

Other Conditions Pulmonary Tuberculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Address West Balt. General Hosp. Date signed 2/4/45 M. D.

92B

VS 130

625538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1700

Registered No. 625538

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County.....
(c) City or town Hanover (If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Laurence M. Wildasin

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Hilda S. Wildasin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1897

8. AGE: Years	Months	Days	If less than one day
47	6	17	..... hr. ..... min.

9. Birthplace York County (Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Lawrence Wildasin
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant Mrs. Hilda Wildasin
(b) Address Hanover, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9 1945 (month) (day) (year)
(c) Cemetery or crematory St. Paul
Location Hanover, Penna.

18 (a) Funeral director Frederick Bercher
(b) Address Hanover Penna

19 (a) FEB 6 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1945, at 6:45 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 4-2
(a) Date of injury February 4, 1945 1:45 P.M.
(b) Where did injury occur? Lombard & Greene Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Collision Autos

23. Signature [illegible] M.D. Medical Examiner.
Date signed 2-5-45

625533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

625533 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ARROW RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 113 The Elderery St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Stanton
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-22-86
8. AGE: Years 58 | Months 6 | Days 14 | If less than one day hr. min.
9. Birthplace D C (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Rubin Stanton
13. Birthplace DC

MOTHER
14. Maiden Name Martha Wilson
15. Birthplace D C

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location C. C. County Md

18 (a) Funeral director Joseph G. Hanka, Jr.
(b) Address 1364 N. Central Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150 FEB 6 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1945 at 10 30d PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1945 to Feb 5 1945 and that I last saw h[illegible] alive on Feb 5 1945.

	Duration
Immediate cause of death: Cardiac arrest	
Due to: Hypertensive Cardiovascular	?
Due to: Disease Pericarditis	9 Wks
Other conditions: Postmenopausal Bilateral hydrothorax	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Williams J. Dixon
Address Johns Hopkins Hosp. Date signed 2/5/45

G25534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G25534

AB-91181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos- 7days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4720 W. Garrison Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche N Wilds

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23- 1867

8. AGE: Years 87 | Months 2 | Days 12 | If less than one day hr. min.

9. Birthplace Maryland (Baltimore)
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Wilds
13. Birthplace England

MOTHER
14. Maiden Name Annie Whlet
15. Birthplace Unknown

16. (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 2/6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 6 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1945, at 10.30 A

21. I certify that death occurred on the date above stated; that I attended deceased from 12-18 1944, to 2-4- 1945, and that I last saw h- alive on 2-4- 1945.

Immediate cause of death Cardiac failure — Duration ?

Due to arteriosclerotic heart disease — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Balto City Hosp Date signed 7-4-40

25535

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

14a

Registered No. G25535

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2608 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry K. Wyatt

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 220-24-3824

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife: Bessie Wyatt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1879

8. AGE: Years	Months	Days	If less than one day
65	8	10	hr. min.

9. Birthplace Elkridge Maryland (Town, county, and state)

10. Usual Occupation Retired Postal Clerk

11. Industry or business U. S. P. O.

FATHER
12. Name Joseph N. Wyatt
13. Birthplace Churchill Maryland

MOTHER
14. Maiden Name Fannie Harper
15. Birthplace Maryland

16 (a) Informant Mr. Francis H. Wyatt
(b) Address 5 Guyon Lake Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/45 (month) (day) (year)
(c) Cemetery or crematory Melville Meth. Cem.
Location Elkridge, Maryland

18 (a) Funeral director William J. Tickner
(b) Address North & Pulaski Evans aves

19 (a) FEB 8 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4, 1945, at 3 A. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Per: Robert Lee Slaton M.D. (Medical Examiner.)
Hugh D. McNally M.D.
Date signed FEBRUARY 5, 1945.

625536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 625536

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: East Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3950 N. North Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stonewall J. Schmenner

3 (b) If veteran, name war	3 (c) Social Security Account No.
- - -	- - -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ella E. Schmenner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-10-1869

8. AGE: Years	Months	Days	If less than one day
75	3	22	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John W. Schmenner
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Sarah Tarbuino
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ella Schmenner
(b) Address 3950 N. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/45 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location Baltimore, Md.

18 (a) Funeral director William J. Tickner & Son
(b) Address North & Pennsylvania Avenues

19 (a) FEB 6 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2, 1945, at 3:20 P. M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury Hugh D. McNally M.D.

23. Signature Robert Le Gru Cain M.D. Medical Examiner.
Date signed February 5, 1945.

VS 151

625537 ✓ 625537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1623 Cherry St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 Cherry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Swierczewski (Swezewski)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife: adela
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
about 61			hr. min.

9. Birthplace Poland. (Town, county, and state)
10. Usual Occupation Boiler Maker.
11. Industry or business Arundel Corp.

FATHER
12. Name
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland.

16 (a) Informant Ida Swierczewski
(b) Address 1623 Cherry

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Highway.

18 (a) Funeral director Wm J. Fiblkowski
(b) Address 2007 Eastern Ave

19 (a) FEB 6 1945 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1945 at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Feb 3 1945, and that I last saw him alive on Feb 3 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration 3 days
Due to Hyper Tension Long Standing
Due to
Other Conditions Myocardial Insufficiency

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon L. Harley M. D.
Address 700 Penn Ave Date signed 2/7/45

625538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

625538 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 423 S. Bond St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 S. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country Poland

3 (a) FULL NAME Kozlowski Paulina

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4 Sex Female | 5 Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Peter Kozlowski

6 (c) If alive, give age About years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years About 64 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business at Home

FATHER 12. Name John Zielinski
13. Birthplace Poland

MOTHER 14. Maiden Name Mary Politow
15. Birthplace Poland

16 (a) Informant Peter Kozlowski Jr.
(b) Address 478 S. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/45 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary
Location Baltimore Md

18 (a) Funeral director Vincent Fiaskowski
(b) Address 1618 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 FEB 6 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1945 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 29 1945 to Feb 4 1945, and that I last saw [illegible] alive on Feb 4 1945

Immediate cause of death ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE — Duration 1 yr.

Due to GENERALIZED VASCULAR SCLEROSIS

Due to

Other Conditions TERMINAL BRONCHO-PNEUMONIA — Duration 2 DAYS

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: —

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Date signed 2/7/45

Address [illegible]

635539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 635539

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please correct age is especially important. Every item of information should be carefully answered. Please write the causes of death clearly and legibly. DO NOT WRITE IN SPACE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3022 Fendall Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3022 Fendall Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE E. STONESIFER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John T. Stonesifer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1855

8. AGE: Years	Months	Days	If less than one day
89	6	6	hr. min.

9. Birthplace Baltimore Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown De Vese
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Marie A. Jones
(b) Address 3022 Fendall Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/45 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

FEB 6 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1945 at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1945, to Feb 4 1945. and that I last saw her alive on Feb. 4, 1945

Immediate cause of death	Duration
Arteriosclerosis	10 yrs
Due to Chronic Myocarditis	5 Yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home; on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. C. Coleman M. D.
Address 1757 W. Mon Date signed 2/6/45

625540

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 181

625540 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Patapsco St
(c) Hospital or institution: Bon Secours Hosp. 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 23
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 S. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Annie Cavalier

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Chas. Cavalier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1872

8. AGE: Years 72 | Months 10 | Days 6 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jewel Angelier
13. Birthplace France

MOTHER 14. Maiden Name Marie Cornell
15. Birthplace France

16 (a) Informant Mrs. Angelo Miles
(b) Address 1530 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Geo L Dwyer Jr
(b) Address 1872 Hollins St

19 (a) FEB 6 1945 (Date received by Local Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/4/1945, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3/1945 to 2/4/1945, and that I last saw h[illegible] alive on 2/4/1945.

Immediate cause of death: Pulmonal Circulatory Failure — Duration: 1 day
Due to Multiple 2nd & 3rd Degree Burns — with
Due to Shock.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident (Fire) 1943
(b) Date of occurrence 2/3/45 at 3 P M
(c) Where did injury occur? Balto 10 S Calhoun St (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? [illegible] was working stove & got fatal fall on
(e) Means of injury Fire
23. Signature Raymond Lynwood Ross M. D.
Address Bon Secours Hosp Date signed

For S.H.B. McNally, by Thomas J. Mullen, M.D. 2/4/45

625541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625541 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2733 Wilkens ave
(c) Hospital or institution: ——
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 20-5
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2733 Wilkens ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Ogle Jr.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Eva H. Ogle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22-1877

8. AGE: Years 67 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired (Checker)
11. Industry or business Stock yards.

FATHER
12. Name William J. Ogle Sr.
13. Birthplace Balto Md

MOTHER
14. Maiden Name Lena Alvater
15. Birthplace Md

16 (a) Informant Mrs Eva H. Ogle
(b) Address 2733 Wilkens ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 7-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Geo. E. Boyer Jr.
(b) Address 1512 Baltimore [illegible]

19 (a) FEB 6 - 1945 (Date rec'd by registrar) (b) 8 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1945 19 at 9:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 41 to Death 19, and that I last saw him alive on Feb. 4. 1945 19

Immediate cause of death: Leukaemia, Chr. Myelogenous. — Duration: 4 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation: 0

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide 0
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? 2 (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Lloyd Johnson M. D.
Address Catonsville, Date signed 2/6/45

VS 160

625542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

A 40

625542 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4418 Reisterstown Rd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 448 Reisterstown Rd
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Pollack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Joseph -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 84

8. AGE: Years 61 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name -
13. Birthplace Russia

MOTHER
14. Maiden Name -
15. Birthplace Russia

16 (a) Informant Mrs. J. Pirah

(b) Address 4223 Pimlico Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-45 (month) (day) (year)

(c) Cemetery or crematory Druadale

Location

18 (a) Funeral director Jos Lewis Inc

(b) Address 1431 E Baltimore St

19 (a) Hunter Stanton Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5-45 19 , at 8 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/18/44 19 , to 2/3 19 45 and that I last saw h alive on 2/3 19 45.

Immediate cause of death	Duration
Acute Coronary Insufficiency	
Due to	
Due to Coronary Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature O. A. Hornstein M.D.

Address 733 Augusta St. Date signed 2/6/45

VS 150

1945

625543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625543 Registered No. 164E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street address 3917 Boarman Ave (If rural give location)
Citizen of foreign country? Yes (Yes or No)
If yes, name country Russia

3 (a) FULL NAME Albert Berman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of ~~husband~~ or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years	Months	Days	If less than one day
39			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Insurance Broker

11. Industry or business

FATHER
12. Name Harry Berman
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Rose Berman (Wife)
(b) Address 3817 Boarman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-45 (month) (day) (year)
(c) Cemetery or crematory Druid Lodge
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address Jack Lewis Inc

19 (a) (Date rec'd by registrar) Huntington Williams, Registrar

95 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1945, at 11:40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 5, 1945 11:20 A.M.
(b) Where did injury occur? Emerson Hotel
(c) Did injury occur at home, on farm, industrial place, in public place? Emerson Hotel (While at work?) No
(d) Means of injury Jumped from 12th Floor

23. Signature Roberts Ted Gratton M.D.
Medical Examiner.
Date signed Feb. 5 1945

G25544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 (Registered No.) G25544

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 E. Lafayette Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anne Anne Sneed

3 (b) If veteran, name war

3 (c) Social Security Account No. 245-34-5180

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wiley Sneed

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/8/1924

8. AGE: Years 20 | Months 1 | Days 26 | If less than one day hr. min.

9. Birthplace Wilkes Co., N.C. (Town, county, and state)

10. Usual Occupation Scales Operator

11. Industry or business Beth. Steel Corp.

FATHER
12. Name Mosley Luffman
13. Birthplace Wilkes Co., N.C.

MOTHER
14. Maiden Name Georgie Love
15. Birthplace N.C.

16 (a) Informant Mosley Luffman
(b) Address Wilkes Co., N.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6th 1946 (month) (day) (year)

(c) Cemetery or crematory
Location Elkin N. C.

18 (a) Funeral director Leo D. Cook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) FEB 6 - 1945 (Date rec'd by Registrar) (b) Hunting for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4, 1945, at 3:40 P M

21. I certify that I took charge of the remains described above, held an ____ thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 12-5
(a) Date of injury February 4, 1944 1:15 A. M.
(b) Where did injury occur? Greenmount & Lafayette
(c) Did injury occur at home, on farm, industrial place, or public place? public While at work? No
(d) Means of injury Struck by auto

23. Signature Robert E. Heaton M.D. (Medical Examiner)
Date signed 2-5-45

VS 151

G25545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30D

G25545 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 1329 Stockton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1329 Stockton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Steve Hawkins

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M
5. Color or race C
6 (a) Single, married, widowed, or divorced. Widower
6 (b) Name of husband or wife Dora
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1/14/1889
8. AGE: Years 55 Months - Days 20 If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Washington Hawkins
13. Birthplace Md

MOTHER
14. Maiden Name Jane
15. Birthplace Md.

16 (a) Informant Jane E. Hawkins
(b) Address 800 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/45 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Wm. H. Kelly
(b) Address 1303 Pennsylvania Ave

FEB 6 - 1945 (Date rec'd by registrar) Clayton Williams, M.D. Registrar

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7 19 45, at 9 30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection / Autopsy / Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac Decompensation Due to Cardiac arteriosclerosis and Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

Signature C. Clayton Williams M.D. Medical Examiner.
Date signed 2/10/45

G-546

JL- 90503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

625546 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 724 Newington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis Tyler Franklin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Clara Ruth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1916

8. AGE: Years 28 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lewis
13. Birthplace Va.

MOTHER
14. Maiden Name Willie May Johnson
15. Birthplace Ala.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 6/1945 (month) (day) (year)

(c) Cemetery or crematory
Location Bristol, Tenn

18 (a) Funeral director John O. Mitchell Home
(b) Address 1900 Eutaw Pl.

19 (a) FEB 6 - 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1945 19 , at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3, 1944 to Feb. 5 1945, and that I last saw h im alive on Feb. 5 1945.

Immediate cause of death Pulmonary Tuberculosis bilateral — Duration 3 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto City Hosp. Date signed 2/6/45

VS 150

G25547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43

Registered No. G25547

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 311 Rossiter Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ELWOOD STARKEY

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-5507

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Cole McDaniel
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1880

8. AGE: Years 64 | Months 3 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Office superintendent

11. Industry or business Keyser Office Bldg.

FATHER
12. Name William H. Starkey
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Elizabeth Jones
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. Norman Starkey
(b) Address 311 Rossiter Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) FEB 8 - 1945 (Date rec'd by registrar) (b) Clifton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1945, at 5:54 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 28 1945 to Feb. 4 1945, and that I last saw him alive on Feb. 4 1945.

Immediate cause of death	Duration
Cardio respiratory failure	
Due to Complete hepatic dysfunction (cirrhosis)	
Due to Blastomycosis infection	
Other Conditions Possible malignancy	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack C. Morgan, M.D. M. D.
Address U.M.H. Date signed 2-4-45

625548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 42D

Registered No. 625548

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4008 Ridgewood Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4008 Ridgewood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIRGINIA THOMPSON RANDALL

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel O. Randall
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 11, 1860

8. AGE: Years: 84 | Months: 3 | Days: 24 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business:

FATHER
12. Name: Capt. John Alex Thompson
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Martha Jane Smith
15. Birthplace: Baltimore, Md.

16 (a) Informant: Miss Mary V. Driscoll
(b) Address: 4008 Ridgewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Md

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave. & Broadway

19 (a) 1945 (Date rec'd by registrar) (b) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION A. M.

20. DATE OF DEATH: Feb. 5 1945, at 8.03 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1944, to Feb 5 1945 and that I last saw her alive on Feb 4 1945.

Immediate cause of death	Duration
Hardening of Arteries	7 yr.
Due to old age	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation: X
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: no
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: A. O'Hearn M. D.
Address 7901 Forrest Park Ave Date signed 2/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

625548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

625549 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the... the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 324 E. 20 1/2 St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 324 E. 20 1/2 St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Cooper

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15/190[illegible]

8. AGE: Years 43 | Months 4 | Days 18 | If less than one day: hr. min. 1901

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name William Cooper
13. Birthplace Va

MOTHER 14. Maiden Name Nellie Cooper
15. Birthplace Va

16 (a) Informant Elizabeth Cooper
(b) Address 324 E. 20 1/2 St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location [illegible] County

18 (a) Funeral director Rayner & Sanders
(b) Address 1412 E. Preston Street

19 (a) Date rec'd by registrar FEB 6 - 1945 (b) Huntingtown Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1945, at 4 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 30 1945 to Feb 3 1945, and that I last saw h[illegible] alive on Feb 3 1945.

Immediate cause of death: Lobar Pneumonia — Duration: 4 da.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 2829 Greenleaf St Date signed Feb 5 1945 M. D.

(OVER)

X

G25550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G25550 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1528 E. Madison St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 - 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1528 E. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hannah Cook

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife John H. Cook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1888

8. AGE: Years	Months	Days	If less than one day
56	11	3	hr. min.

9. Birthplace Baltimore County (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name Elizabeth Berry
15. Birthplace Baltimore County

16 (a) Informant John H. Cook
(b) Address 1528 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location A A County Md.

18 (a) Funeral director Mrs. Rosetta A. Elliott & Dgt.
(b) Address 1129 N. Caroline Street

19 (a) Date received by registrar FEB 6 - 1945 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1945, at 9:42 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1945 to Feb 5th 1945, and that I last saw h-e alive on Feb 5th 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage (Left Hemiplegia)	2 days
Due to Dysentery (?)	
Due to Myocarditis	
Other Conditions Nephritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Albert A. Lafarest
Address 822 N. Bond St Date signed 2/6/45

X

625551

AB-27462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 625551

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Be sure the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7yrs- 3mos-16days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 208 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Forderer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17- 1863

8. AGE: Years	Months	Days	If less than one day
81	10	12	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Patrick Kelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/45 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Frederick Road

18 (a) Funeral director John F. Sakenhaus
(b) Address 3912 Edgewood St.

19 (a) FEB 6 1945 (Registrar) Hunter-Lee Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29- 1945 at 9.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13 1937, to 1-29 1945, and that I last saw h. or alive on 1-29- 1945.

Immediate cause of death	Duration
Coronary occlusion	1 day
Due to arteri-sclerosis	?
Due to Cardiac inefficiency hypertensive heart disease	8yrs.
Other Conditions fract. left femur.	8-10 yrs.
	7 yrs.

(Include pregnancy within 3 months of death)

Date of operation 10-16-37

Major findings of operation: fract femur.

of autopsy: Card failure Coronary occlusion Fract femur

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 6/5
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 10-13-37 at ? M
(c) Where did injury occur? Balt. Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury Slipped + fell to pavement in front of home

23. Signature Hauck & Bellon M. D.
Address Balt. Md. Date signed 2/5/45

To be approved by the Medical Examiner
For A. C. S. Summers - J. Howard T. Mueller, M.D.

VS 150

625552

L - 91946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183a

Registered No. 625552

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 S. Potomac St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Schuck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Div.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1883 ?

8. AGE: Years	Months	Days	If less than one day
61 ?	6 ?	16 ?	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name George L. Schuck
13. Birthplace Md.

MOTHER
14. Maiden Name Louisa Henning
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern ave Rd

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

19 (a) FEB 6 - 1945 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1945, at 2:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4, 1945, to Feb 4 1945, and that I last saw her alive on Feb. 4 1945.

Immediate cause of death cerebral accident, probably hemorrhage — Duration 6 hr.

Due to

Due to

Other Conditions gen. arteriosclerosis; bronchopneumonia (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. B. Perry, J.
Address City Hosp. Date signed 2-5-45 M. D.

VS 150

G25553 | BALTIMORE CITY HEALTH DEPARTMENT | G25553

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address NORTH BROADWAY Church Home + Hospital
(c) Hospital or institution:
Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 70 Dunhill Road.
(If rural give location)
(e) Citizen of foreign country? O (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Sophia Gabris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife Mr. John Gabris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 14, 1889

8. AGE: Years	Months	Days	If less than one day
55	10 11	12 2 2	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name Frank Evon
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Katharine Ross
15. Birthplace Czechoslovakia

16 (a) Informant Papa
(b) Address

17 (a) Ba-Ial (b) Date thereof 2/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.
18 (a) Funeral director Stephen J. Fialkowski
(b) Address 1000 S. Kenwood Ave.
19 (a) (b)
(Date rec'd by Registrar) FEB 6 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1945, at M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1945 to Feb 5 1945 and that I last saw h e alive on 31/5/45 1945.

Immediate cause of death	Duration
[redacted]	
Due to CONGESTIVE HEART FAILURE	2 weeks
Due to [redacted]	
Other Conditions Arteriosclerotic heart disease	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M Irvin N. Davis M. D.
Address Church Home Date signed 2-5-45

625564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (93)

Registered No. 625554

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19 W. Camden St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 19 W. Camden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country no

3 (a) FULL NAME: John Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Maggie Adams

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.): 1880

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace: Chester Penna. (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: Rev. Adams
13. Birthplace: Penna

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Maggie Adams
(b) Address: 19 W. Camden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/45 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location: Cedar Hill md.

18 (a) Funeral director: A. O. Halstead
(b) Address: 916 Druid Hill Ave.

19 (a) FEB 6 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3 1945, at 1.00 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to nature's death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B McNally M.D. Medical Examiner.
Date signed 2/4/45

VS 151

G25555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93C

Registered No. G25555

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: DOA Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2105 Lovegrove St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Chester Wilson

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 32 31 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business .....

FATHER
12. Name Edward Wilson
13. Birthplace Oxford North Carolina

MOTHER
14. Maiden Name Ida Hawkins
15. Birthplace ?

16 (a) Informant Edward Wilson
(b) Address 2105 Lovegrove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams Registrar

FF 2345

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3 1945, at 2.40 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rheumatic Cardio-Vascular Disease

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature H. Engle B. McDonald M.D. Medical Examiner.

Date signed 2/14/45

G25556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

G25556 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith
(c) Hospital or institution:
Motherhouse of Notre Dame 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sr.M.Louise Weber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6,1892

8. AGE: Years 52 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Newark N.J.
(Town, county, and state)

10. Usual Occupation Religious

11. Industry or business Teacher

FATHER
12. Name John Weber
13. Birthplace New York

MOTHER
14. Maiden Name Mary Murphy
15. Birthplace Ireland

16 (a) Informant Sr.M.Stan.Kostka
(b) Address 901 Aisquith Street

17 (a) Burial (b) Date thereof Feb 8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt.St.Cliff
Location Glen Arm

18 (a) Funeral director Geo M. Fowler & Son
(b) Address 511 N Calvert St

19 (a) FEB 6 1945 (Date received by Registrar) (b) Whitington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb.6 1945 at 5.40AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec.30 1942, to Feb.6, 1945, and that I last saw her alive on Feb.2, 1945.

Immediate cause of death Carcinoma Cervix abdominal Metastases — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E J Kirby
Address 1108 North Ave Date signed 2/6 45 M. D.

X

G25557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

Registered No. G25557

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully completed. Physicians: please write the causes of death clearly and legibly. Be sure that age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ——
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 Hanover St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME G. William Dorsch

3 (b) If veteran, name war None
3 (c) Social Security Account No. 218-10-0772

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Anna R. Dorsch
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Jan 11, 1893

8. AGE: Years	Months	Days	If less than one day
52	-	24	..... hr. ..... min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Rigger
11. Industry or business Johnsen & Anderson

FATHER
12. Name Don't know
13. Birthplace Germany

MOTHER
14. Maiden Name Don't know
15. Birthplace Germany

16 (a) Informant Mrs Anna R Dorsch
(b) Address 1819 Hanover

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 5 1945 (month, day, year)
(c) Cemetery or crematory Cedar Hill
Location Md

18 (a) Funeral director R. Howard Evans
(b) Address Md

FEB 6 - 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1945 at 9:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to Feb 5 1945 and that I last saw him alive on Jan 5 1945.

Immediate cause of death	Duration
Lobar pneumonia bilaterally	
Due to following a	
Due to Obstetrical prostatectomy (supra pubic)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Jan 13, 1945
Major findings of operation: Benign Prostatic Hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. M. Bacon Jr M. D.
Address St Josephs Hospital Date signed 2-5-45

VS 150

625558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. G25558

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25
(c) Hospital or institution: South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 3215 Old Annapolis Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Septimus L. Cage

3 (b) If veteran, name war: WW
3 (c) Social Security Account No. 205-10-5893

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Frances E. Cage
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 24 1879
8. AGE: Years 65 Months Days 11 If less than one day hr. min.
9. Birthplace Abingdon Harford Co (town, county, and state)
10. Usual Occupation Retired Bridge Tender
11. Industry or business Western Md

FATHER
12. Name James Cage
13. Birthplace Abingdon Md

MOTHER
14. Maiden Name Mary Turner
15. Birthplace Md

16 (a) Informant William L. Cage
(b) Address 1234 E. Fort Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Feb. 4, 1945 (month) (day), (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director A. Howard & Sons
(b) Address 1400 Eutaw St

FEB 6 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1945, at 3 P M

21. I certify that I took charge of the remains described above, held an Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C-V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. Lisowski M.D. (Medical Examiner.)
Date signed 2/5/45

G25559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G25559 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Elwood Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 442 E. Lorraine Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Julia A. O'Sullivan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Leo O'Sullivan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/20/1890

8. AGE: Years	Months	Days	If less than one day
54	7	18	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Conner
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Burke
15. Birthplace Ireland

16 (a) Informant Miss Elizabeth O'Sullivan
(b) Address 442 E. Lorraine Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5??? Ponfret Rd.

FEB 6 1945

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6/45 19 , at 9:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/5/45 19 , to 2/6/45 19 , and that I last saw h-- alive on 2/5/45 19

Immediate cause of death Cardiorespiratory Failure — Duration

Due to Basilar Skull Fracture

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident 12/3
(b) Date of occurrence 2-4-45 at 7 M
(c) Where did injury occur? 442 E. Lorraine ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Fell down basement stairs

23. Signature J. Frank Supplee MD
Address Union Memorial Hospital Date signed 2/6/45 M.D.

VS 150

For B.H.B. McNally, by Howard J. Mascetty, M.D.

G25560

G25560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3600 White Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3600 White Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Maria Garrett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Michael A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29 - 1858

8. AGE: Years 86 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace Hutton - Garrett Co. -
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Martin Hughes
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Martin
15. Birthplace Ireland

16 (a) Informant Mrs. Robert B. Garrett
(b) Address 3600 White Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-45 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Lanzyd Co.

18 (a) Funeral director L. J. Kuntz
(b) Address 5305 Harford Rd

19 (a) FEB 6 - 1945 (Date rec'd by registrar) (b) Hunting & Williams Reg. Dist.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1945, at 1:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1936 to Feb 5 1945, and that I last saw her alive on Feb. 5 1945

Immediate cause of death Carcinoma caecum — Duration 3 yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. A. Klein M. D.
Address 6217 Harford Rd Date signed 2-6-45

G25561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1700

Registered No. G25561

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md - (b) County Howard
(c) City or town Elkridge (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mack Duncan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma L Duncan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/1883 ~~1877~~

8. AGE: Years 61+5 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace Crystal Va (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER — 12. Name Jacob Duncan
13. Birthplace Va

MOTHER — 14. Maiden Name Matty E Phillips
15. Birthplace Va

16 (a) Informant Stevens Funeral Home
(b) Address Crystal Va

17 (a) Funeral (burial, cremation, or removal) (b) Date thereof 2/6/45 (month) (day) (year)

(c) Cemetery or crematory Crystal
Location Crystal Va

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul Street

19 FEB 6 - 1945 (Date rec'd by registrar) Huntington-on-Williamson, W.Va. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1945, at 1:00 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 5 1945 12:20 A M.
(b) Where did injury occur? Waterloo, Md - Howard Co.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Struck by Automobile

23. Signature Robert Lee Fortune M.D. Medical Examiner.
Date signed 2-5-45

(over)

correct age is especially important. Physicians: please write the cause of death clearly and legibly. The item of information should be carefully [illegible]

G25562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

Registered No. G25562

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ... 15 A
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 weeks
(e) Length of stay in Baltimore (yrs., mos., or days) ...

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ...
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 Fairfax Rd.
(If rural give location)
(e) Citizen of foreign country? ... (Yes or No)
If yes, name country ...

3 (a) FULL NAME Thomas R. Tomicki

3 (b) If veteran, name war ...

3 (c) Social Security Account No. ...

4. Sex: MALE

5. Color or race: White

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife CATHERINE M. DUANE

6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) SEPTEMBER 4, 1917

8. AGE: Years 27 | Months 5. | Days 1 | If less than one day ... hr. ... min.

9. Birthplace NEW YORK
(Town, county, and state)

10. Usual Occupation FOREMAN

11. Industry or business BETH. FAIRFIELD SHIPYARDS

FATHER
12. Name VICTOR TOMICKI
13. Birthplace POLAND

MOTHER
14. Maiden Name ANNA GODZAK
15. Birthplace POLAND

16 (a) Informant MR. JOHN. TOMICKI
(b) Address 246 JERSEY PLACE N. J.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/9/45 (month) (day) (year)

(c) Cemetery or crematory St Michaels Cem
Location Astoria New York —

18 (a) Funeral director JOHN J. COWAN & SONS
(b) Address 901-03 HOLLINS STREET

FEB 6 - 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1945, at 2.40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Compound fractures of ribs, bilateral; atelectasis of lungs; fibrino-purulent

Due to pleurisy bilateral

Other Conditions ...

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/23/45 at 25/6 3 54 M.
(b) Where did injury occur? Beth. Fairfield Shipyards
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? YES
(d) Means of injury By fall from truck on which was walking on road.

23. Signature Robert Lee Slater M.D.
Medical Examiner.

Date signed Feb. 6 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully ascertained.

625563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 625563

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1316 EUTAW PLACE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WINIFRED C. DUNPHY

3 (b) If veteran, name war	3 (c) Social Security Account No.
----	----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Married

6 (b) Name of husband or ~~wife~~ Patrick J. Dunphy
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1889

8. AGE: Years	Months	Days	If less than one day
55	4	3	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Patrick Haney
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Ellen Welsh
15. Birthplace Ireland

16 (a) Informant Miss Mary E. Dunphy
(b) Address 1316 Eutaw Place

17 (a) Burial (b) Date thereof 2/7/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas J Evans & Son
(b) Address 118 W. Mt Royal Ave.

19 (a) FEB 6 1945 (b) Huntington Williams, M.D.
(month) (day) (year)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1944, to Feb. 4 1945, and that I last saw h.e alive on Feb. 3 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Old arteriosclerotic	
Due to Hypertension	4 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benj Cohen
Address Marlboro Md Date signed 2/6/45 M. D.

G25564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G25564
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Woodbine
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Fleming.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male

5 Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1943

8. AGE: Years 1 | Months 20 | Days 29 | If less than one day hr. min.

9. Birthplace Md. - Carroll Co
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Fred Fleming
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Bell Pickett
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-45 (month) (day) (year)
(c) Cemetery or crematory Morgan Chapel
Location Woodbine Carroll Co. Md.

18 (a) Funeral director E. M. Waltz
(b) Address Winfield Md

19 (c) FEB 7 - 1945 (Date rec'd by registrar) (b) Hunter Jon Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 - 19 45, at 5.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 6 - 1945 to Feb. 6 1945, and that I last saw him alive on Feb. 6 - 1945

Immediate cause of death	Duration
Shock (Waterhouse Friedrichsen's Syndrome)	12 hrs ±
Due to Septicemia due to pelvic meningococcus	3 days
Due to Meningitis (pneumococcus meningococcus)	3 days
Other Condition	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Reed K. Christiansen M.D.
Address Johns Hopkins Hospital Date signed 2/7/45

625563
467412

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 63B

Registered No. 625563

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Bryan. (If outside city or town limits, write RURAL and give town)
(d) Street No. 533 West Bryan. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mildred Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Paul H Edwards

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 8-16-1911

8. AGE: Years 33 | Months 5 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Home-wife

11. Industry or business

FATHER
12. Name Amos B. Zuber.
13. Birthplace Ohio

MOTHER
14. Maiden Name Mary Bowlsby.
15. Birthplace JOHNS HOPKINS HOSPITAL

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 6/45 (month) (day) (year)

(c) Cemetery or crematory
Location Bryan, Ohio

18 (a) Funeral director Von D. Mitchell Home
(b) Address 1900 Eutaw Pl.

19 (a) FEB 7 - 1945 (Date rec'd by registrar) (b) Registrar for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6, 1945, at 5.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 17 1945 to Feb. 6 1945, and that I last saw her alive on Feb. 6 1945

Immediate cause of death Thyroid Storm (Post Operation) — Duration 2 days

Due to Hyper thyroidism — 3 years

Due to

Other Conditions

(Include pregnancy within three months of death)

Date of operation 2/3/45

Major findings of operation: Tonic Thyroid Adenoma

Findings of autopsy: Not Obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan C Woods Jr.
Address Johns Hopkins Hospital Date signed 2/6/45

VS 150

625566

JO #35090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 625566

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6yrs 6mos 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 S. Savage St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Paul H. Hoyer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1869-70?

8. AGE: Years 74-75? | Months -1- | Days 15 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Paul
13. Birthplace Germany

MOTHER
14. Maiden Name Lydia Smith
15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7 (month) (day) (year)
(c) Cemetery or crematory LORAINE PARK
Location Woodlawn Md

18 (a) Funeral director Daniel Della Rocca
(b) Address

FEB 7 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1945, at 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-81 1938 to 2-5 1945, and that I last saw h/m alive on 2-5 1945.

Immediate cause of death	Duration
Myocardial infarction	5 min
Due to arteriosclerosis	
Due to	
Other Conditions Hardening arteriosclerosis (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy: none	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospitals Date signed 2-6-45

VS 130

625567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625567 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. Balto.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2852 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME E. Allene Trimmer

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-1856

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 25 / 03

8. AGE: Years 41 | Months 9 | Days 10 | If less than one day: hr. min.

9. Birthplace York, Pa.
(Town, county, and state)

10. Usual Occupation Secretary

11. Industry or business Gatch Wire Co.

FATHER
12. Name Frank Trimmer
13. Birthplace Frederick Md.

MOTHER
14. Maiden Name Harriet R. Lease,
15. Birthplace Frederick Md.

16 (a) Informant Frank D. Trimmer,
(b) Address 2852 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 8. 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director George W. Little,
(b) Address 2700 Edmondson Ave.

19 Filed FEB 7 1945 (b) Huntington Hill Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 / 5 1945, at 2 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 1944, to 2/5 1945, and that I last saw h.e.r. alive on 2/5 1945.

Immediate cause of death	Duration
Metastatic Ca to Lungs + Brain.	
Due to Ca of Breast.	
Due to Malignancy of Duct.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Ullsperger M.D.
Address Mercy Hosp. Date signed 3/5/45

625568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

625568 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 237 S. Madeira
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 257 S Madeira
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Grasser

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary Grasser

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19 1869

8. AGE: Years 75 | Months 3 | Days 15 | If less than one day: hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Frank Grasser
13. Birthplace Balto

MOTHER
14. Maiden Name Dont know
15. Birthplace Balto

16 (a) Informant Mrs James R Cook
(b) Address 257 S Madeira

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Balto, Md

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St

19 (a) FEB 7 1945 Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 4 19 45 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 19 45 to Feb. 4 19 45, and that I last saw h[illegible] alive on Feb. 3 19 45.

Immediate cause of death	Duration
Gastric Hemorrhage	24 hrs
Due to Carcinoma of stomach ?	
Due to	
Other Conditions Pernicious Anemia	3 mos.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas J Douglas M. D.
Address 700 E. Pratt St. Date signed 2/5/45

25569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. G25569 29310½

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rehwood & Greene Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 Parish St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Baby Girl Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/1/45

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Newborn
11. Industry or business

FATHER
12. Name David Robinson
13. Birthplace Virginia

MOTHER
14. Maiden Name Mandy Suber
15. Birthplace Charlotte, N. C.

16 (a) Informant Mandy Robinson
(b) Address 1106 Parish St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL FEB 6 1945
18 (a) Funeral director Commissioner of Health
(b) Address
19 FEB 7 1945 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/4/1945 at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1/1945 to 2/4/1945 and that I last saw h.E.A. alive on 2/4/1945

Immediate cause of death	Duration
Respiratory failure	
Due to Intracranial hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Dean Pinchal, M. D.
Address Univ. Hosp. Date signed 2/4/45

VS 3

2492

625570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 625570

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1518 Aisquith Street
(c) Hospital or institution: 9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 Aisquith St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rose L. Tinker

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles E. Tinker
6 (c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Dec. 15, 1885

8. AGE: Years	Months	Days	If less than one day
59	I	20	######### min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Frank O. Moran
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Catherine Gies
15. Birthplace: Baltimore, Md.

16 (a) Informant: Charles E. Tinker Sr.
(b) Address: 1518 Aisquith Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9th, 1945 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Park
Location: Baltimore County

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) Date received by Registrar: FEB 7 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 5 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to Feb 5 1945. Said that I last saw h.. alive on Feb 5 1945.

	Duration
Immediate cause of death: Cerebral hemorrhage	
Due to: hypertension and arteriosclerosis	
Due to:	
Other Conditions: Blindness	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Francis T. Rogusky, Jr. M. D.
Address: 800 N. Patterson Park Ave. Date signed: 2-5-45

G25571
AE-91291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B ✓

Registered No. G25571

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 324 East 22nd. 1/2 Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Claiborne or George Claybourne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9-1901

8. AGE: Years	Months	Days	If less than one day
43	9	25	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John (D)
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary (D)
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 8 43 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Q. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E PRESTON St

19 (a) FEB 7 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1945, at 8:28 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1944 to Feb 4 1945, and that I last saw h~~im~~ alive on Feb 4 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	1 yr.
bilateral	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Hilton M. D.
Address Balto City Hosp. Date signed 2/6/45

VS 150

G25572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G25572

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32nd & Charles St.
(c) Hospital or institution: Allston Apts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 32nd & Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. JOHNSTON

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Ralph P. Johnston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1887

8. AGE: Years	Months	Days	If less than one day
57	3	9	hr. min.

9. Birthplace New Freedom, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard C. Ward
13. Birthplace New Freedom, Pa.

MOTHER
14. Maiden Name Margaret Anderson
15. Birthplace Pa.

16 (a) Informant Mr. Ralph P. Johnston
(b) Address 32nd & Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/1945 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director WM. H. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 2-7-45 (Date rec'd by registrar) (b) Huntington Hill, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1944 to Feb 4 1945.
and that I last saw her alive on Feb 3 1945.

Immediate cause of death	Duration
Myocardetis	Gradual
Due to Arterio-Sclerosis Deabetes Mellitus	Gradual
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W H Moody M.D.
Address 1403 Park Ave Date signed 2/5/45

VS 150

25573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 25573

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3930 Belvieu Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3930 Belvieu Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRIET ELLA KEYSER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Rev. S. Gedney Keyser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1857

8. AGE: Years	Months	Days	If less than one day
87	6		hr. min.

9. Birthplace -
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name - Groves
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name -
15. Birthplace -Conn.

16 (a) Informant Mr. J. T. Dowling
(b) Address Munsey Bldg.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 2-7-45 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1943, to Feb. 5 1945, and that I last saw h[illegible] alive on Feb 4 1945.

Immediate cause of death	Duration
Adeno Carcinoma of right Breast with	
Due to metastases to intestines	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2200 Garrison Blvd Date signed 2-7-45

VS 150

625574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1370

Registered No. 625574

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1738 E. 25th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mr. George H. Taylor (George Harmon Taylor)
3 (b) If veteran, name war: None
(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife: Mary Clapperton Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1866

8. AGE: Years	Months	Days	If less than one day
78	11	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired Supt.
11. Industry or business Baking Business

FATHER
12. Name Robert Taylor
13. Birthplace Unknown

MOTHER
14. Maiden Name Cecelia M. Harmon
15. Birthplace Unknown

16 (a) Informant Mr. G. Fred Taylor
(b) Address 1738 E. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 2-7-45 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 1945, at 6.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1945 to 2/6 1945, and that I last saw him alive on 2/6 1945

Immediate cause of death	Duration
Uremia : Terminal Bronchopneumonia	
Generalized Carcinomatosis	
Due to Hypertrophied Prostate	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2/2/45
Major findings of operation: Hypertrophied Prostate
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. McFadden M. D.
Address St. Joseph's Hosp. Date signed 2/6/45

VS 150

625575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. 625575

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 307 S. Fremont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Y
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 S. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward S. Wheeler

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 219-16-277

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Wheeler
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) July-19-1899

8. AGE: Years 45 | Months 6 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore - Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Edgewood Arsenal

FATHER
12. Name Jerry W Wheeler
13. Birthplace Calvert Co - Md

MOTHER
14. Maiden Name Nancy Stevens
15. Birthplace Calvert Co. Md

16 (a) Informant Mary Wheeler
(b) Address 307 S. Fremont

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-45 (month) (day) (year)
(c) Cemetery or crematory Baetz-National Cem
Location

18 (a) Funeral director James Artayo
(b) Address 142 W. Hill St

19 (a) FEB 7 - 1945 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5 1945, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1945 to 2/5 1945, and that I last saw h[illegible] alive on 2/4 1945.

Immediate cause of death Coronary Thrombosis 1 day

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 2-7-45

625576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14

Registered No. 625576

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 627 Cumberland St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 Cumberland St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Madeline Williamson (Watts)

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age 1902

7. Birth date of deceased (mo., day, yr.) Aug 24 1902

8. AGE: Years 43 | Months 5 | Days 11 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Chas. F. Watts

13. Birthplace Md

14. Maiden Name Annie M. Wise

15. Birthplace Md

16 (a) Informant Annie Watts

(b) Address 627 Cumberland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Wes. H. Kelson

(b) Address 1303 Presstman St

FEB 7 - 1945 (Date rec'd by registrar) Huntington for Williams Mortuary

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5/45, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9/45, to 2/5/45, and that I last saw h alive on 2/5/45

Immediate cause of death	Duration
(a) Cerebral Embolism	
Due to (b) Arteriosclerosis	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Dan Rhetta M. D.

Address 1 W Saratoga St Date signed 2/5/45

X

G25577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1942

Registered No. G25577

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 Whitridge Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 Whitridge Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael J. Gunning

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Catherine Ellis Gunning
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 25, 1865

8. AGE: Years 79 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace Texas Balto. Co., Md. (Town, county, and state)
10. Usual Occupation Retired Stone
11. Industry or business Setter

FATHER
12. Name John Gunning
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen B. Ellis
15. Birthplace Ireland

16 (a) Informant Mrs. Catherine Hartman
(b) Address 437 Whitridge Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral Cemetery
Location 4800 Old Frederick Rd.

18 (a) Funeral director Elmer O. Conklin & Son
(b) Address 924 E. Eager St.

FEB 7 - 1945 (Date rec'd by Registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1945, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31-1945 to 2-4-1945, and that I last saw him alive on 2-3-1945

Immediate cause of death: Apoplexy — Duration: 3 days
Due to Arteriosclerosis — Duration:
Due to
Other Conditions Arteriosclerotic coronary disease — Duration: 1 year
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(d) Means of injury

23. Signature Geo. B. Sybert M. D.
Address 2807 Harford Ave Date signed 2-5-45

625578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V115B

625578 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be especially important. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Greene

(c) Hospital or institution: Univ. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 | 16

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 828 N. Mount St. ~17 (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Lillie Key Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Brown	married

6 (b) Name of husband or wife Riley Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
51 yrs			hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Moses Johnson

13. Birthplace Md.

MOTHER

14. Maiden Name Wilson

15. Birthplace Md.

16 (a) Informant Riley Jones

(b) Address 828 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7, 1945 (month) (day) (year)

(c) Cemetery or crematory Waterbury, Md.

Location

18 (a) Funeral director Mrs Kate R Williams

(b) Address 322 N Schroeder St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

FEB 7 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3/45 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1/45 19 to 2/3/45 19, and that I last saw her alive on 2/2/45 19

Immediate cause of death — Heart failure, Pulmonar edema, as gloml nephritis

Due to Hypertension as gloml nephritis

Due to Septic Throat post tonsillar abscess

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J.W. Mulz, M. D.

Address Univ. Hosp. Date signed

X

625579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

625579 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1926 McCulloh
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 1/4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1926 McCulloch St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Ashby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 67 S.T. | Months | Days | If less than one day hr. min.

9. Birthplace Frederick, Maryland
(Town, county, and state)

10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Unknown Ashby
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Annie Ashby
15. Birthplace Frederick, Md

16 (a) Informant Lillie Selby
(b) Address 1110 N. Mount St

17 (a) Burial (b) Date thereof 2 8 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto Md

18 (a) Funeral director Archibald Gaddis
(b) Address 2101 McCulloh St.

19 (a) FEB 7 - 1945
(Entry read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/4 1945 at 10:40 A M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broncho - pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Irvin B. McNally M.D.
Medical Examiner.
Date signed 2/6/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

Huntington Williams, M.D.

~~25580~~ BALTIMORE CITY HEALTH DEPARTMENT 625580

CERTIFICATE OF DEATH 1945 Registered No. 940

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1808 Baker Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 Baker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Clifford Burke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1863

8. AGE: Years	Months	Days	If less than one day
81	4	2	hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Retired

FATHER
12. Name William Burke
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name — Waymouth
15. Birthplace Va.

16 (a) Informant Mrs Emma Burke
(b) Address 1808 Baker St.

17 (a) Burial (b) Date thereof 2/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location

18 (a) Funeral director William J Pickney
(b) Address North & Penna aves.

19 (a) FEB 7 - 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1945, at 10 P. M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Per: Hugh B. McNally, M.D.
23. Signature Robert Le Gittam M.D.
Medical Examiner.
Date signed February 5, 1945.

VS 151

625581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1370

Registered No. 625581

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2737 Edmondson Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2737 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM H. CARTER

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mamie Carter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/3/1863

8. AGE: Years	Months	Days	If less than one day
81	7	3	hr. min.

9. Birthplace Baltimore Co., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. George W. Coppard -Sister in Law
(b) Address 2737 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/45 (month) (day) (year)
(c) Cemetery or crematory Fork Cem.,
Location Balto. Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

FEB 7 - 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6, 1945, at 1:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1944, to Feb 6 1945, and that I last saw h- alive on Feb 6 1945.

Immediate cause of death Cardiac Asthma. — Duration 3 hr.
Due to Hypertension. Arteriosclerosis — 2 yr.
Due to Hypertrophy Prostate — 5 yr.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Woodward M.D.
Address 1202 St Paul St Date signed 2/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G25582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G25582
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkins Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Sylvan Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsworth House

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-5499

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: May House

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 11, 1895

8. AGE: Years 49 | Months 9 | Days 25 | If less than one day hr. min.

9. Birthplace Laurel Md
(Town, county, and state)

10. Usual Occupation Inspector
11. Industry or business D.C.A.

FATHER
12. Name Henry House
13. Birthplace Md.

MOTHER
14. Maiden Name Lana McCabee
15. Birthplace Md

16 (a) Informant Harry House
(b) Address Ellicott City Md

17 (a) Burial (b) Date thereof 2-9-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Johns
Location Ellicott City

18 (a) Funeral director H.C. Kinnebrew
(b) Address Ellicott City Md

19 (a) 7-1945 (b) Huntington Williams, M.D.
(Undertaker's or local registrar's record) Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 1945 at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1945 to 2/6 1945, and that I last saw h.i.s. alive on 2/6 1945.

	Duration
Immediate cause of death: Cardiac failure	
Due to: Shock	
Due to:	
Other Conditions: Typhoid fever	

(Include pregnancy within 3 months of death)

Date of operation 2-6-45
Major findings of operation: Typhoid fever
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard W Hines M. D.
Address St Agnes Hosp Date signed 2-6-45

625583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

625583 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2715 E.Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2715 E.Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriett Lloyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Howard T.Lloyd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23-1882

8. AGE: Years 62 | Months 9 | Days 18 12 | If less than one day hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Joshua Lockwood
13. Birthplace England

MOTHER
14. Maiden Name Alice J.Laughton
15. Birthplace England

16 (a) Informant Raymond H.Lloyd
(b) Address 2715 E.Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb.8/45 (month) (day) (year)
(c) Cemetery or crematory St.Matthews Cem.
Location O.Donnell St.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

FEB 7 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1944 to 2/5 1945 and that I last saw her alive on 2/5 1945.

Immediate cause of death	Duration
Carcinoma of Rectum	1 yr
Due to Extending to Liver	
Due to Intestines	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Cancelled
Major findings of operation: Carcinoma of Rectum
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide /
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury /

23. Signature A. C. Kearney M. D.
Address 7901 Eastern Ave Date signed 2/6/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL - 90 625584 BALTIMORE CITY HEALTH DEPARTMENT G25584
CERTIFICATE OF DEATH 13B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 624 Conway St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Gross

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Cora
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1892

8. AGE: Years 52 | Months 5 | Days 23 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Gross
13. Birthplace Md.

MOTHER
14. Maiden Name Minnie Hesson
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/45 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W. Montgomery St.

19 (a) FEB 7 - 1945 (Date rec'd by registrar) (b) Huntington Woodlawn, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30 1945, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1944, to Jan. 30 1945, and that I last saw h. in alive on Jan. 30 1945.

Immediate cause of death: Pulmonary tuberculosis — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto. City Hosp. Date signed 1/31/45

625585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

625585

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 Days.

2. USUAL RESIDENCE OF DECEASED:
(a) State W Va (b) County Green Brier
(c) City or town Rupert
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME R. Orange McClung
3 (b) If veteran, name war (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Lillie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12-26-74

8. AGE: Years	Months	Days	If less than one day
70	1	11	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Charley McClung
13. Birthplace W Va

MOTHER
14. Maiden Name Nancy Shawver
15. Birthplace W. Va.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2-9-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Church Cemetery
Location Dunmore W. Va.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) (Date rec'd by Registrar) FEB 7 1945 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1945 at 12 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1945 to Feb 6 1945 and that I last saw h alive on Feb 6 1945

Immediate cause of death	Duration
Rupture of aortic aneurysm	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus M.D.
Address Johns Hopkins Hosp Date signed 2/6/45

625586

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 30 E

625586 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 d
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Carolina (b) County
(c) City or town Lumberton (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Kinlaw

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6 1900

8. AGE: Years	Months	Days	If less than one day
44.	4	29.	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Carpenter.
11. Industry or business

FATHER
12. Name Archie Kinlaw
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Sarah Allen.
15. Birthplace N. Carolina.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 7 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 Date rec'd by registrar FEB 7 1945 Harry J. Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5 1945, at 9 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25 1944, to 2/5 1945, and that I last saw him alive on 2/5 1945.

Immediate cause of death	Duration
Cardiac and Pulmonary failure	
Due to Aortic Insufficiency	
Due to Luetic C.V.D.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Allspergen M. D.
Address Mercy Hosp. Date signed 2/5/45.

VS 150

2494 X

Marlow -
6304 Belair Rd 625587

(1)

625587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1817 E. Federal St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 E. Federal St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. Kilbinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna M. Kilbinger
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) July 20 - 1876

8. AGE: Years	Months	Days	If less than one day
68	6	15	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Andrew Kilbinger
13. Birthplace Germany

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Anna M. Kilbinger
(b) Address 1817 E. Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd

19 (a) (Date rec'd by registrar) (b) Registrar: Hunting Williams

FEB 7 - 1945

VS 158

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/8 1943 to 2/5 1945 and that I last saw him alive on 2/3 1945

Immediate cause of death Carcinoma of Stomach — Duration 2 yrs +

Due to

Due to

Other Conditions Chronic Myocarditis — unknown

(Include pregnancy within 3 months of death)

Date of operation 1943. St. Joseph's Hosp.

Major findings of operation: Carcinoma of stomach

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John W. Machen M.D.
Address 6304 Belair Rd Date signed 2/6/45 M. D.

Medical Art + Bldg
Novak

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G25538
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2225 Lake Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2225 Lake Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. D'Angelo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Salvatore D'Angelo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26-1883

8. AGE: Years	Months	Days	If less than one day
61	2	11	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name James D'Antonis
13. Birthplace Italy

MOTHER
14. Maiden Name Catherine D'Antonis
15. Birthplace Italy

16 (a) Informant Mr. Salvatore D'Angelo
(b) Address 2225 Lake Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Leonard J. Ruck
(b) Address 53[illegible] Harford Rd.

19 (a) FEB 7 - 1945 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1945, at 7a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940, to Feb 6 1945, and that I last saw h[illegible] alive on Feb 5 1945.

Immediate cause of death Carcinoma of Liver — Known — Duration 2 months

Due to ?

Due to

Other Conditions Diabetes mellitus
Paralysis agitans
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Novak M. D.
Address 101 W. Read St Date signed 2-6-45

Pesagno
2314 E. Baltimore St.

625583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 118

625583
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4207 Parkwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4207 Parkwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Monius

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Margaret C. Monius
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) June 13-1882

8. AGE: Years	Months	Days	If less than one day
62	7	21	hr. min.

9. Birthplace Balto - Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name George Monius
13. Birthplace Md.

MOTHER
14. Maiden Name Madalene Bielefeld
15. Birthplace Md.

16 (a) Informant Mrs. Margaret C. Monius
(b) Address 4207 Parkwood Aven.

17 (a) Burial (b) Date thereof 2-7-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Leonard J. Luck
(b) Address 5345 Harford Rd.

19 (a) FEB 7 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4th 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 31, 1945 to Feb. 4, 1945; and that I last saw h. alive on Feb. 3, 1945.

Immediate cause of death Pyloric obstruction — Duration 2.

Due to 2.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene L. Pesagno M. D.
Address 5144 Drury Lane Date signed 2/7/45

VS 150

Huntington Williams, M.D.

X

625530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 625580

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution:
Church Home & Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 490 E. 32nd St. Balto. Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Not Known

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-8-1884

8. AGE: Years 60 | Months 7 | Days 27/30 | If less than one day ..... hr. ..... min.

9. Birthplace Illinois
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business Dept. Store

FATHER
12. Name Andrew Lindblade
13. Birthplace Sweden

MOTHER
14. Maiden Name Ottalie Aden
15. Birthplace Sweden

16 (a) Informant Ruth Martin
(b) Address 490 E. 32nd St, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-45 (month) (day) (year)

(c) Cemetery or crematory Moreland Memorial
Location

18 (a) Funeral director L. J. Rynck
(b) Address 5-30 E Hanford Rd.

19 (a) FEB 7 - 1945 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-4 1945, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4-44 19.. to 2-4 1945, and that I last saw h[illegible] alive on 2-4 1945.

Immediate cause of death	Duration
Carcinoma of Ascending Colon	
Due to Metastasis & extension of Carcinoma of Colon	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James B. Lindblade, M.D.
M. D.
Address Church Home & Hosp. Date signed 2-6-45

X

625591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 625591

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 E. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert N. Jarvis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife McKinnon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1911

8. AGE: Years: About 33 | Months | Days | If less than one day: hr. min.

9. Birthplace Norfolk Va.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Food Fair Inc.

FATHER
12. Name William E. Jarvis
13. Birthplace Va.

MOTHER
14. Maiden Name McKinnon
15. Birthplace "

16 (a) Informant Thomas A. Jarvis Brother
(b) Address Timonium Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 7-45 (month) (day) (year)

(c) Cemetery or crematory Norfolk Va
Location Norfolk Va

18 (a) Funeral director William Cook Inc
(b) Address 217 St Paul Street

19 (a) FEB 7 - 1945 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1945 at 5:03 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions History of Epilepsy

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb 4, 1945 4/1 M.
(b) Where did injury occur? 115 E. Franklin St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Probable accidental fall

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb. 5 1945

VS 151

(over)

625592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

625592 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2907 Ridgewood Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur D. Page

3 (b) If veteran, name war M | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed or~~ divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Maude
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 22nd 1881

8. AGE: Years	Months	Days	If less than one day
63	5	14	hr. min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation Electrical Clerk
11. Industry or business Women's Hospital

FATHER
12. Name George P. Page
13. Birthplace Unknown

MOTHER
14. Maiden Name Julia Wills
15. Birthplace Unknown

16 (a) Informant Maude Page
(b) Address 2907 Ridgewood Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/8/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Rock Creek
Location Washington D.C.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) FEB 7 - 1945 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6, 1945, at 9 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1945 to Feb. 6 1945 and that I last saw him alive on Feb. 6, 1945.

Immediate cause of death Myocardial insufficiency — Duration

Due to Coronary Heart disease Arteriosclerosis, generalized

Due to

Other Conditions Chronic fibro-caseous Tuberculosis & scoliosis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley A. Keirle, M.D.
Address Sinai Hospital Date signed 2/6/45

940

625593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

114E

625593
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write carefully supplied information should be carefully supplied. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West BALTIMORE GENERAL HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 N. BRICE STREET
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLIFTON EARL HARRINGTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar 30th 1927

8. AGE: Years 17 | Months 10 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Rabbi Bakery

FATHER
12. Name Ralph Harrington
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Eva Alder
15. Birthplace Balto. Co. Md

16 (a) Informant Mrs Eva Harrington
(b) Address 601 N. Brice St

17 (a) Burial (b) Date thereof 2/8 45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto Md.

18 (a) Funeral director William Bok - 2c
(b) Address 1213 St Paul St

19 (a) FEB 7 - 1945 (b) Hunter Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1945 at 7 25 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy/Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Freiman M.D.
Medical Examiner.
Date signed Feb 6th 1945

VS 151

625594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 117a

Registered No. 625594

Please write in ink or use typewriter. Information should be carefully supplied (see other side) and the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 424 W. 26th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace E. Harwood

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Gordon Harwood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10th 1895

8. AGE: Years	Months	Days	If less than one day
49	9	25	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At home

FATHER
12. Name William Shipley
13. Birthplace Unknown

MOTHER
14. Maiden Name Margaret "
15. Birthplace "

16 (a) Informant Mildred Stoney
(b) Address 441 W. 24th St

17 (a) Burial (Burial, cremation, re-cremation) (b) Date thereof 3-8-45 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Faulkner

18 (a) Funeral director William Cook Inc
(b) Address 217 St Paul St

19 (a) [illegible] (b) [illegible]
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5- 1945, at 6 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Generalized peritonitis

Due to Perforation of gastric ulcer

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mallonee M.D.
Medical Examiner.
Date signed 2-6-45

(60533)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registry No. 60533

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1206 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Kocher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband ~~or wife~~ Henry Kocher
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Oct 10th 1882

8. AGE: Years	Months	Days	If less than one day
62 62	3	26	hr. min.

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Dominick Kupfer
13. Birthplace Hungary

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Henry Kocher
(b) Address 1206 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto Md

18 (a) Funeral director William Cook Inc
(b) Address 1209 St. Paul St

19 (a) FEB 7 - 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 1945 at 8:30 M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally Medical Examiner.
Date signed 2/6/45

VS 151

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625596 108 (Registered No.) 625596

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 N Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 N Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Robert L. Winston Sr

3 (b) If veteran, name war —
3 (c) Social Security Account No. 218-01-3655

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Rachel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28 1876

8. AGE: Years	Months	Days	If less than one day
68	2	6	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Harry E Winston Jr
(b) Address 822 Eutaw Pl
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.
18 (a) Funeral director William Cook Inc
(b) Address 127 E Lexington St Huntington Williams, Md
19 (a) (b) Registrar
(Date received by registrar)
FEB 7 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1945, at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29-1945 to 2-4-1945 and that I last saw h ~~im~~ alive on 2-4-1945.

Immediate cause of death	Duration
Myocardial failure	3 days
Due to Lobar pneumonia	7 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Jno B. Sybert M. D.
Address 2802 Harford Rd Date signed 2-5-45

G25597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G25597
Registered No.

Important: Information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DIA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 Eutaw Pl.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phillip Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 4, 1870

8. AGE: Years 74 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace St Marys Co Md
(Town, county, and state)

10. Usual Occupation Tabacco Business

11. Industry or business Own

FATHER
12. Name Phillip Henry Dorsey
13. Birthplace Md

MOTHER
14. Maiden Name Annie Bryon
15. Birthplace Md

16 (a) Informant L Lobey Stone
(b) Address 3933 Entaw Pl

17 Buried (b) Date thereof 2/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Old Saints
Location St Marys Co Md

18 (a) Funeral director Tallon & Son
(b) Address 1201 E Fort Ave

19 (a) (Date rec'd by registrar) (b) Lexington Williams M.D. Registrar

FEB - 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 1945, at 5:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Clinton Gerbrich M.D.
Medical Examiner.
Date signed 2/6/45

625598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 625598

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Please correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2101 Old Spring Lane

(c) Hospital or institution: Old Spring Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1004 E. Fenton St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose M. Riley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~ widowed, or divorced
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ David K. Riley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22nd 18[illegible]

8. AGE: Years	Months	Days	If less than one day
75	11	10 14	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Invalid

11. Industry or business Nursing Home

FATHER: 12. Name John E. Glenn

13. Birthplace Ireland

MOTHER: 14. Maiden Name Mary Grady

15. Birthplace Ireland

16 (a) Informant William F. Riley

(b) Address 1004 E. Fenton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-8-45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 127 S. Paca St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6th 1945, at 2.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1942 to Feb 6 1945, and that I last saw her alive on Feb 2 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to	
Due to	
Other Conditions senility (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. N. Patterson M. D.

Address 2924 Reisterstown Rd Date signed 2/6/45

X

625599 625599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. Balto.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town near Granite
(If outside city or town limits, write RURAL and give town)
(d) Street No. Old Court Rd. - Balto 7.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Zoe Perry. (Zoe Marian Perry)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Gilbert J Perry.

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) March 21 26, 1892

8. AGE: Years 52 ~~53~~ | Months 10 | Days ~~10~~ 15 | If less than one day ..... hr. ..... min.

9. Birthplace Northfield Vermont.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name James Cofrin
13. Birthplace Vermont

MOTHER
14. Maiden Name Gertrude Hatch
15. Birthplace Vermont

16 (a) Informant Mr. Gilbert J. Perry
(b) Address Old Court Rd, nr Granite, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 8, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director E. W. Donovan
(b) Address 4510 Liberty Heights Ave.

19 (a) 1945 (b) Rec'd by registrar Lurton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 1945 at 2 ~~AM~~ PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 1945, to 2/6 1945
and that I last saw her alive on 2/6 1945.

	Duration
Immediate cause of death: Cerebral Hem. - Spon. (ventricular)	Hrs.
Due to: Hypertensive C.V.D.	Years.
Due to: Essential Hypertension.	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Spon. Ventric. Hem.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Ullsperger M.D.
Address Mercy Hosp Date signed 2/6/45

X

G25600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G25600

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 402 Northway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 Northway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Reuneburg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Lucie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, ~~yr.~~): July 20 1877

8. AGE: Years 67 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Vice Pres. & Treasurer

11. Industry or busine Edw Reuneburg Co.

FATHER
12. Name Edward Reuneburg
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Brickman
15. Birthplace Balto. Md.

16 (a) Informant Lucie Reuneburg
(b) Address 402 Northway

17 (a) Burial (b) Date thereof 2/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St. Paul St

FEB 8 1945 (b) Huntington Williams M.F.
Date received by Registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7th 1945, at 7:32 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1-44 to Feb 7th 1945 and that I last saw him alive on 2/7/45

Immediate cause of death: Myocardial Degeneration — Duration: 6 mos

Due to: Coronary Thrombosis — Duration: 6 mos

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. M. Herrmann

Address 1710 E 33rd St Date signed 2/7/45
M. D.

625601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

625601 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2917 Christopher Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2917 Christopher Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur M. Payne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Julia B. [redacted]

6 (c) If alive, give age: Balto years

7. Birth date of deceased (mo., day, yr.) Feb 13th 1880

8. AGE: Years 64 | Months 11 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Dorchester Co. Md.
(Town, county, and state)

10. Usual Occupation President

11. Industry or business Curtains Shirts Corsetry Co

FATHER
12. Name Thomas L. M. Payne
13. Birthplace Dorchester Co. Md

MOTHER
14. Maiden Name Sarah Elizabeth Foxwell
15. Birthplace Dorchester Co. Md.

16 (a) Informant Julia B. Payne
(b) Address 2917 Christopher Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/45 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Park Knlls Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) Filed FEB 8 1945 (Date filed by Registrar) (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7th 1945, at 9 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19..., and that I last saw h... alive on ..... 19....

Immediate cause of death: Uraemia
Conv. & coma.
Due to: Chr. nephritis.
Arterio sclerosis
Due to:

Other Conditions: Diabetes, Chr. valv. Heart Disease
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

Duration
3 days
+ yrs.
20 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 2120 N. Charles Date signed 2/7/45 M.D.

(OVER)

1310

<23502
71 - 91872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 623602

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2224 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: George J. Lang

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, ~~1888~~ 1888

8. AGE: Years 56 ~~55~~ | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Insurance Salesman

11. Industry or business

FATHER
12. Name Frederick Lang
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rose Buchardt
15. Birthplace Switzerland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1417 St Paul St

19 FEB 8 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1945, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30 1945 to Feb. 5 1945, and that I last saw h im alive on Feb. 5 1945.

Immediate cause of death Pulmonary tuberculosis — Duration 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Perry J.
Address City Hosp. Date signed 2-8-45 M. D.

(over)

625603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G25603 (new)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2nd
(c) Hospital or institution: Mt. Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Nogansbury
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rural
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William W. White

3 (b) If veteran, name war W
3 (c) Social Security Account No 095-07-6244

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of ~~husband~~ or wife Louise White
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 24 1908
8. AGE: Years 36 | Months 1 | Days 11 | If less than one day hr. min.
9. Birthplace Nogansbury N.Y. (Town, county, and state)
10. Usual Occupation Welder
11. Industry or business Bethlehem Steel Works

FATHER
12. Name Fred White
13. Birthplace St. Regis Falls N.Y.

MOTHER
14. Maiden Name Mary Terrance
15. Birthplace Nogansbury N.Y.

16 (a) Informant Mrs Louise White
(b) Address 1312 Bolton St
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/8/45 (month) (day) (year)
(c) Cemetery or crematory Massena
Location Massena N.Y.
18 (a) Funeral director Gilbert Undertaking Co
(b) Address 124 E. Lexington St
19. Date received FEB 8 1945 Registrar Huntington for Williamson M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5 1945, at 3:05 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 2-4 1945 to 2-5 1945 and that I last saw him alive on 2-5 1945

	Duration
Immediate cause of death Lobar Pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Louis Goldman M.D.
Address Mt. Sinai Hospital Date signed 2-5-45

625604
AB-91968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

625604
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alma Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) (40?)

8. AGE: Years	Months	Days	If less than one day
40?	?	?	hr. min.

9. Birthplace Ala.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jeff Coleman
13. Birthplace Ala.

MOTHER
14. Maiden Name Mary
15. Birthplace Ala.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof FEB 9 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director A. F. Scholl and Sons
(b) Address 9 E. Lexington

19 FEB 8 1945 (Date received by Registrar) (b) Huntington, Indiana, Mar 8 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6- 1945, at 8:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 1945, to 2-6- 1945, and that I last saw h 9F alive on 2-6- 1945.

Immediate cause of death miliary Tuberculosis — Duration ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. A. Kurz M. D.
Address City Hosp. Date signed 2-7-45

625605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B Registered No. 625605

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 768 W. Mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 76 & W. Mulberry
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carter Sarah Jones.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colored	Married

6 (b) Name of husband or wife John R. Carter
(c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace St Mary's Co. Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Grandison Bonds
13. Birthplace Md

MOTHER
14. Maiden Name unknown
15. Birthplace Md

16 (a) Informant John R. Carter
(b) Address 768 W Mulberry St

17 (a) Burial (b) Date thereof 2/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 FEB 8 - 1945 (b) Huntington White Registrar
(Date rec'd by Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1945, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 29 1945, to Feb 4 1945, and that I last saw her alive on Feb 3 1945.

Immediate cause of death	Duration
Mitral Insufficiency	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Edward Fisher M. D.
Address 1612 E Monument Date signed Feb 6 45

625606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625606 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2504 W. Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2037 W. Fayette St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Kierschner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23 - 1860

8. AGE: Years 84 | Months 4 | Days 15 | Hours 4 | Under 1 day: hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant John R. J. Kierschner
(b) Address 2504 W Fayette St

17 (a) Burial (b) Date thereof Feb 10 - 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loraine Park Cem
Location

18 (a) Funeral director Charles F. Powell
(b) Address 4427 Edmondson Ave

FEB 8 - 1945 (b) Huntington Wilson
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7 1945, at 6 20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Thrombosis

Due to

Other Conditions Arteriosclerotic Cardiovascular

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Falkenstein M.D.
Medical Examiner.
Date signed 2/8/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

625607

Registered No. 3698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1144 N. Carey St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1144 N. Carey St (If rural give location)

(e) Citizen of foreign country? (Yes or No) ✓

If yes, name country

3 (a) FULL NAME Lovie Grass.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Wm I Grass

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12-25-1883

8. AGE: Years 59 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Nth Hampton Co Va. (Town, county, and state)

10. Usual Occupation ~~Farmer~~ House Wife

11. Industry or business

FATHER 12. Name Osa Dix

13. Birthplace Va

MOTHER 14. Maiden Name Emily ?

15. Birthplace ?

16 (a) Informant Wm I Grass

(b) Address 1144 N. Carey St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 2-9-45 (month) (day) (year)

(c) Cemetery or crematory Capmore Cemetry

Location Capmore. Virginia.

18 (a) Funeral director William A Jackson

(b) Address 916 Penna Ave

19 (a) (Date received by Registrar) FEB 8 - 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1945, at 4:30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-4- 1945 to 2-6 1945. and that I last saw her alive on 2-5- 1945.

Immediate cause of death — Broncho pneumonia

Due to

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 6 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Frank A. Saunders M.D. M. D.

Address 1029 N. Stricker St. Date signed 2-7-45

107

625608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

625608 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not guess, but write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1418 W. Mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30. yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 418 W. Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Lizzie Stenson (STINSON)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Albert

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10-2-1878

8. AGE: Years 66 | Months 3 4 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Alabama (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Henry Williams
13. Birthplace Ala

MOTHER
14. Maiden Name Famie ?
15. Birthplace Ala

16 (a) Informant Albert Stenson
(b) Address 1415 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 10-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna Ave

19 (a) (Date received by registrar) FEB 8 1945 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7. 1945 4.20 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1945 to 2-7 1945, and that I last saw h[er] alive on 2-7 1945

Immediate cause of death Lobar pneumonia — Duration mos

Due to Hypostatic congestion — Duration days

Due to Rheumatic heart disease — Duration Years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1200 Madison Ave 2/7/45

625609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1178 Registered No. 625609

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 730 North Linwood (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Gertrude Riggin, Mrs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Benson Riggin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1893

8. AGE: Years 51 | Months 7 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank D. Reynolds
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mrs Emma Russ
15. Birthplace Baltimore

16 (a) Informant Patient
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Road

18 (a) Funeral director John L. Denny, Inc.
(b) Address 715 Light St. (by) Huntington Williams, M.D.

FEB 8 - 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1945, at 1.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31 1945 to 2-7 1945, and that I last saw her alive on 2-7 1945.

Immediate cause of death	Duration
Shock	
Due to acute peritonitis	
Due to Perforation of duodenal stump	
Due to following Gastric resection	
Other Conditions Arteriosclerosis, Rheumatism	

(Include pregnancy within 3 months of death)

Date of operation 1-31-45

Major findings of operation: Chronic duodenal ulcer with chronic perforation into pancreas, acute peritonitis, generalized

of autopsy: Perforation of duodenal stump

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Steuart Hatch M. D.
Address Church Home Hospital Date signed 2-7-45

VS 180

625610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625610 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4221 Morrison Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4221 Morrison Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Phillip J. Vaeth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edith H. Vaeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1887

8. AGE: Years 57 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Pipe fitter

11. Industry or business Standard Phosphate Works

FATHER
12. Name George Vaeth
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Hughes
15. Birthplace Maryland

16 (a) Informant Edith H. Vaeth
(b) Address 4221 Morrison Court

17 (a) Burial (b) Date thereof 2/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St.

19 (a) FEB 8 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1945 at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1944 to Feb 5 1945, and that I last saw him alive on 2/5 1945.

Immediate cause of death	Duration
coronary occlusion	
Due to hypertension cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip A Kirsten MD
Address 302 Patapsco Av Date signed 2/8/45
M. D.

VS 150

X Kirsten

625611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 625611

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5024 Belle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5024 Belle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY W. HERMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1874

8. AGE: Years	Months	Days	If less than one day
74	7	0	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation General Clerical Work
11. Industry or business U. S. Gov't. P. O.

FATHER
12. Name Henry W. Herman
13. Birthplace Germany

MOTHER
14. Maiden Name Rose D. Oehrl
15. Birthplace Balto., Md.

16 (a) Informant Mr. John G. Herman
(b) Address 3710 Egerton Rd.

17 (a) Burial (b) Date thereof 2/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

FEB 8 - 1945 Hunter Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6, 1945, at 11:45a M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/4 1945 to 2/6 1945 and that I last saw h[illegible] alive on 2/6 1945

Immediate cause of death	Duration
Asphyxia	
Pneumonia	
Due to Bed sores	
Due to	
Other Conditions old age	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 801 Eutaw Pl. Date signed 2/7/45

VS 150

625612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Registered No. 625612

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Broadway & Fairmount Aves.
(c) Hospital or institution: Church Home and Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 3510 Copley Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) **FULL NAME** Anna Mae Omohundro

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: William H. Omohundro

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 18, 1889

8. AGE: Years: 55 | Months: 8 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: William Walbrecher
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Minnie Kuhlman
15. Birthplace: Balto., Md.

16 (a) Informant: Mr. William H. Omohundro
(b) Address: 3510 Copley Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2/10/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

FEB 8 - 1945 (Date rec'd by registrar) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 - 7 1945, at 2:17 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 - 28 1944, to 2 - 7 1945, and that I last saw h er alive on 2 - 7 1945

Immediate cause of death: Cerebral Embolism — Duration: of Less

Due to: Post operative + Post-Irradiation Pelvic

Due to: Thrombophlebitis — 36 days

Other Conditions: Epithelioma of Bladder Grade 3, Papillary Type — 3 years

(Include pregnancy within 3 months of death)

Date of operation: 1 - 2 - 45

Major findings of operation: Recurrent Carcinoma of Bladder

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: [illegible] M. D.

Address: Date signed:

X Deaths

625613 ✓ 625613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1170

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Date of birth and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 Thomas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Hamlet

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife Bella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-15-[illegible]

8. AGE: Years	Months	Days	If less than one day
58 66	11	22	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Sam
13. Birthplace ?

MOTHER
14. Maiden Name Nancy Henley
15. Birthplace Va

16 (a) Informant Rosenda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Feb. 10, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Hartley Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 8 - 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1945 at 9 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1945 to Feb 7 1945 and that I last saw him alive on Feb 7 1945

Immediate cause of death Uremia

Due to Nephrosclerosis ? Hypertension

Due to

Other Conditions P.O. Pneumonia, P.O. Hemorrhage ? Anemia
(Include pregnancy within 3 months of death)

Date of operation 2-3-45

Major findings of operation: Chronic gastric ulcer

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Burnley M.D.
Address J. H. H. Date signed 2-7-45

(OVER) X

625614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 625614

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 505 Cumberland St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Cumberland St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert L. Pennington

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23 1897

8. AGE: 47 Years | Months 1 | Days 11 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Waiter.

11. Industry or business

FATHER
12. Name Nelson Pennington
13. Birthplace Long Green, Md.

MOTHER
14. Maiden Name Sarah Mason
15. Birthplace St. Mary Co., Md.

16 (a) Informant Louis Pennington
(b) Address 505 Cumberland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 10 '45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Katie R. Williams
(b) Address 922 N. Schroeder St.

FEB 8 - 1945 (Date rec'd by registrar) (Signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 19 43 - 1015 A, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 19 43 to 2/6 19 43 and that I last saw him alive on 2/5 19 45

Immediate cause of death: Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 2139 [illegible] Date signed 2/6 1945

(OVER)

VS 150

625615

BALTIMORE CITY HEALTH DEPARTMENT ✓ 625615

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or Institution: Mercy Hosp. 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 853 Tyson Ave. Balt. 1. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Tyler.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Archibald Tyler.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15 85

8. AGE: Years 60 | Months 4 | Days 21 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER 12. Name Lloyd Thompson.
13. Birthplace Maryland.

MOTHER 14. Maiden Name Alice Jolley.
15. Birthplace Va.

16 (a) Informant James H. Tyler.
(b) Address 853 Tyson Ave. Balt. 1.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 10, '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Katie R. Williams
(b) Address 399 N. Schroeder St.

19 (a) FEB 8 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-6- 1945, at 3 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1945 to 2-6 1945 and that I last saw her alive on 2-6- 1945

Immediate cause of death Cerebro Vasc. Hemorrhage, Hemiplegia

Due to Senile Cerebro Vascular Sclerosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Houston L. Lee M.D.
Address Mercy Hosp. Date signed 2/6/45

X

62561.6 ✓ 62561.6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95-C

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1624 Pressbury St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 Pressbury St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Etelia Sifscoomb

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife James Sifscomb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18 1863

8. AGE: Years 51 | Months 4 | Days 23 | If less than one day hr. min.

9. Birthplace Jamesville, N. C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name John Forest.
13. Birthplace N. C

MOTHER 14. Maiden Name Lucy Allisten
15. Birthplace N. C.

16 (a) Informant Stanley Sifscomb.
(b) Address 1624 Pressbury St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 8, '46 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location

18 (a) Funeral director Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) FEB 8 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5/46 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1946 to 2/5 1946 and that I last saw her alive on 2/3/1946

Immediate cause of death	Duration
Coronary Occlusion	
Due to Cardiac Arthritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ben Rhett M. D.
Address 2134 Date signed 2/6/46

626617 ✓ 626617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 N. Fremont ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 18
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 N. Fremont ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? ——— years

3 (a) FULL NAME Mary Black Turnage

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	Divorced

6 (b) Name of husband or wife William Turnage
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) not Known

8. AGE: Years	Months	Days	If less than one day
48	—	—	..... hr. ..... min.

9. Birthplace Salisbury, N. Carolina
(Town, county, and state)
10. Usual Occupation Laundress
11. Industry or business

FATHER
12. Name not Known
13. Birthplace not Known

MOTHER
14. Maiden Name not Known
15. Birthplace not Known

16 (a) Informant Deering Braxton
(b) Address 1143 W. Saratoga st

17 (a) Burial (b) Date thereof Feb. 8, '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Katie R. Williams
(b) Address 322 N. Schroeder st

19 (a) FEB 8 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 February 1945, at 6:15 p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 31 Dec 1944, to 4 Feb 1945, and that I last saw her alive on 3 Feb 1945.

Immediate cause of death: cardio renal disease — Duration: ?
Due to: myocarditis
Due to:
Other Conditions: arterial Hypertension
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James M. Pair M. D.
Address 400 N. Carrollton ave Date signed 2.5.45

James M. Pair

625618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

625618 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Do not use abbreviations. Where the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Forest Glen Manor (If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Easton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earle Trautz.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-5-44

8. AGE: Years	Months	Days	If less than one day
	9 10	1	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Earle Trautz
13. Birthplace Penn

MOTHER
14. Maiden Name Florence Belcher
15. Birthplace W. Va

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 9 45 (month) (day) (year)
(c) Cemetery or crematory Dublin
Location Hartford Co. Md

18. (a) Funeral director James J. Brydzinski
(b) Address 1607 Edmondson Ave. East

19 (a) FEB 9 1945 (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1945, at 8.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 6 1945 to Feb. 6 1945 and that I last saw him alive on Feb. 6 1945.

	Duration
Immediate cause of death Cardiac failure	
Due to Bronchopneumonia	1 day
Due to	
Other Conditions Hyperpyrexia Febrile convulsions (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul E. Wilson
Address Johns Hopkins Hosp. Date signed 2/9/45 M. D.

X

625619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

67 Registered No. 625619

Please answer all questions as correctly and completely as information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 Fremont Ave
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 S. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Shirley Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16 44

8. AGE: Years	Months	Days	If less than one day
	5	15	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation ✓

11. Industry or business

FATHER
12. Name Preston Brown
13. Birthplace Va.

MOTHER
14. Maiden Name Marie Sanns
15. Birthplace Baltimore Md

16 (a) Informant Marie Brown
(b) Address 212 S Fremont Ave

17 (a) Burial (b) Date thereof 2/9/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location B.A.C. Md

18 (a) Funeral director Isaiah L Brown Son
(b) Address 1058 W Monty Omery Street

19 (a) FEB 8 (b) 1945 [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 1945, at 2 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester Greaton M.D.
Medical Examiner.
Date signed Feb 1 1945

VS 151

625620

BALTIMORE CITY HEALTH DEPARTMENT 93D

CERTIFICATE OF DEATH

625620 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 16 W. York Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sherman Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	M

6 (b) Name of husband or wife Blue

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/1888

8. AGE: Years	Months	Days	If less than one day
56 65	1	10	hr. min.

9. Birthplace Greenville N C (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Allen Hall
13. Birthplace N C

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant Bessie Hall
(b) Address 14 W York

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 8 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A Co Md

18 (a) Funeral director Isaiah L Broadnax
(b) Address 108 W Montgomery Street

19 (a) FEB 8 1945 (Date received by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5- 1945, at 3:10 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L Graham M.D. (Medical Examiner.)
Date signed February 5, 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73D

626621

Registered No.

Please write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 817 Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joseph Williams

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Charles Medley
(b) Address 133 W Hill St

17 (a) Burial (b) Date thereof 2/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto. Co. Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) FEB 9 1945 (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-4- 1945, at 5:10 A M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 2-4-45

VS 151

G25822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

G25822 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Grave
(c) Hospital or institution:
Univ. Hosp. 2nd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 839 Clinton
(If rural give location)
(e) Citizen of foreign country? and (Yes or No)
If yes, name country

3 (a) **FULL NAME** Hattie Brown

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem	blk	single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
52	-	—	— hr. - min.

9. Birthplace ?
(Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Self
(b) Address

17 (a) Burial (b) Date thereof 2/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem'y
Location Baltimore Md
18 (a) Funeral director Isaac L. Brown Sons
(b) Address 1054 W. Monument St.
19 (a) FEB 8 - 19 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5th 1945, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1945, to Feb 5 1945, and that I last saw he alive on Jan 5 1945.

Immediate cause of death	Duration
embolism b pulmonary	
Due to	
Due to	
Other Conditions fracture left femur	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 2/2
(a) Accident, suicide, or homicide
(b) Date of occurrence Jan 27 at 6.30 P M
(c) Where did injury occur? Balt. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? on street (Specify type of place) While at work?
(e) Means of injury fell on ice (in front of 839 Clinton St.)
23. Signature Kenneth M. Browne M. D.
Address Univ. Hosp. Date signed 2-5-45

VS 150

For S.H.B. McCauley, by Thomas J. Mancini, M.D. X

625623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓108

625623 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 315 1/2 Forrester Street

(c) Hospital or institution:

5-

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 315 1/2 Forrest (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME alice Bee

3 (b) If veteran, name war

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1890

8. AGE: Years	Months	Days	If less than one day
54	8	20	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER

12. Name James Bee

13. Birthplace Va

MOTHER

14. Maiden Name Julia Watson

15. Birthplace Maryland

16 (a) Informant Mary Millar

(b) Address 315 1/2 Forrester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 | 9 | 45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Baltimore Md

18 (a) Funeral director Isaiah L Brown Dow

(b) Address 1050 Montgomery Street

19 (a) (Date rec'd by City registrar) (b) Huntington Wilkerson, M.D.

FEB 6

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 · 5 · 1945 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 29 1945, to Feb 5 1945, and that I last saw him alive on Feb. 5 1945.

Immediate cause of death Acute Myocarditis — Duration 24 Hours

Due to Lobar Pneumonia — 7 Days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm. A. Berry M. D.

Address 1420 E. Chase Date signed 2-8-45

X

G25624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B Registered No. G25624

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 Pennsylvania (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Garner Pye

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lula
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9-13-92
8. AGE: Years 52 | Months 4 | Days 23 | If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Shoe Shiner
11. Industry or business

FATHER
12. Name Charles Pye
13. Birthplace Md

MOTHER
14. Maiden Name Lottie Green
15. Birthplace Md.

16 (a) Informant Recorder
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-45 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem. Location Balto., Md.

18 (a) Funeral director Charles K. Law
(b) Address 1800 Madison Ave.

FEB 8 1945

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1945 at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1945 to Feb 6 1945, and that I last saw h[illegible] alive on Feb 6 1945

	Duration
Immediate cause of death: Respiratory failure	
Due to: acute bacterial parotitis	4 da.
Due to: Carcinoma of pancreas with extension to retroperitoneal wall & abdominal lymph nodes (Include pregnancy within 3 months of death)	4 mos

Date of operation None
Major findings of operation: Autopsy
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at A M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William J. Dixon
Address Johns Hopkins Hospital Date signed 2/6/45

VS 190

625625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625625 / 31 Registered No. 625625

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 N. Milton Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 N. Milton Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCES MATHIA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or ~~wife~~ Stephen Mathia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3, 1873

8. AGE: Years	Months	Days	If less than one day
72 yrs.	1	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Josepheck
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Blaha
15. Birthplace Czechoslovakia

16 (a) Informant Olga F. Janssen (daughter)
(b) Address 704 N. Milton Avenue

17 (a) Burial (b) Date thereof 2/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Oak Hill
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) Filed 2-8-1945 (b) Rec'd by Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 1945, at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1940 to Feb 6 1945, and that I last saw her alive on 2/6 1945.

Immediate cause of death	Duration
Hypertensive CV disease	
Cardiac Hypertrophy	
Due to Fib. Rheumatic 1st Degree Comp.	
Due to Arteriosclerosis	
Other Conditions Hemiplegia Chr. Nephritis Uremia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas E Schimunek
Address 601 Reisterstown Date signed 2/9/45

VS 150

625626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

625626 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Hanover
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2325 N Lexington Ave
(If rural give location)
(e) Citizen of foreign country? ... (Yes or No)
If yes, name country

3 (a) FULL NAME William Harry Lardnskey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~
M	W	Married

6 (b) Name of husband or wife Eleanor Lardnskey

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Oct 19 1868

8. AGE: Years	Months	Days	If less than one day
76	3	17	... hr. ... min.

9. Birthplace New Castle Delaware
(Town, county, and state)

10. Usual Occupation Retired Fireman

11. Industry or business Municipal Water Dept

FATHER 12. Name Wm K Lardnskey

FATHER 13. Birthplace Balto Md

MOTHER 14. Maiden Name Sarah A Robinson

MOTHER 15. Birthplace Balto Md

16 (a) Informant Mrs Eleanor Lardnskey

(b) Address 2325 N Lexington Ave Balto

17 (a) Burial (b) Date thereof Feb 9 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto Md

18 (a) Funeral director Bartgis Bros

(b) Address 2224 E Baltimore St

19 (a) ... (b) ...
(Date rec'd by reg.) Registrar

VS 150 FEB 8 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1945, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1945 to Feb. 6 1945 and that I last saw him alive on Feb. 6 1945.

Immediate cause of death	Duration
Lobar Pneumonia - Hypostatic	4 days
Due to	
Due to	
Other Conditions Hypertensive C.V.D.	

(Include pregnancy within 3 months of death)

Date of operation ...

Major findings of operation: ...

of autopsy: Cerebral thrombosis & pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ...
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ...
(Specify type of place)
(e) Means of injury ...

23. Signature M. L. Palmer M. D.

Address University Hospital Date signed 2/6/45

G25627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G25627 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 St Dunstans Rd
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Ballotsty (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 St Dunstans (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Howell

3 (b) If veteran, name war: No
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Anne L. Howell
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 20 1860

8. AGE: Years 84 | Months 11 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Educator —
11. Industry or business Education —

FATHER
12. Name George Howell
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Virginia Matthews
15. Birthplace Southern Maryland

16 (a) Informant Mr Roger Howell (son)
(b) Address 4705 Keswick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Stuart Moyn Co.
(b) Address 108 W Madison.

19 (a) ... (b) ... (Date rec'd by registrar) Registrar

vs 150 FEB 8 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6, 1945, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1937, to Feb 6, 1945, and that I last saw him alive on Feb 6 1945

	Duration
Immediate cause of death: Coronary occlusion	1 hour
Due to: Arterio-sclerosis	7 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature N. B. Herman M. D.
Address 1041 St. Paul St. Date signed 2-6-45

N. B. Herman

G25628

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1945 G25628 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore
(b) Street address 700 No. 40th St
(c) Hospital or institution:
Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Camilla J. Heubele
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) October 6 - 1868
8. AGE: Years 76 Months 4 Days 1 If less than one day hr. min.
9. Birthplace Brooklyn Maryland (Town, county, and state)
10. Usual Occupation Teacher - Retired
11. Industry or business

FATHER
12. Name Eli J. Heubele
13. Birthplace Westminster - Maryland

MOTHER
14. Maiden Name Elizabeth Thomas
15. Birthplace Ayle Arundle Co Maryland

16 (a) Informant Emily Barefield - R.N.
(b) Address Home for Incurables
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 7. 45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.
18 (a) Funeral director John O. Mitchell Sons
(b) Address 1700 Eutaw Place
19 (a) 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 1945, at 12.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1944, to Feb. 7 1945, and that I last saw her alive on 2/2/ 1945.

	Duration
Immediate cause of death: Acute Myocardial (Insufficiency)	Sudden
Due to: Arteriosclerotic Cardio Vascular Disease	Several years
Due to:	
Other Conditions: Arthritis Deformans Multiple Joints	8 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thomas Conrad Wolf M.D.
Address 11 E. Chase St. Date signed 2/7/45

V8 3

G25629 BALTIMORE CITY HEALTH DEPARTMENT G25629
CERTIFICATE OF DEATH 1108 Registered No.

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33½ + Calvert
(c) Hospital or institution: Union Memorial Hosp II
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Eutaw + Lanvill Sts. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Mrs. William~~ FERRILL (Jennie) (Jennie S. Ferrill)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Wm. FERRILL
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 3-29-64
8. AGE: Years 80 | Months 6 | Days 7 | If less than one day ..... hr. ..... min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Hsm
11. Industry or business
FATHER 12. Name Wm. Moore
13. Birthplace Va
MOTHER 14. Maiden Name Amelia Straith
15. Birthplace Va
16 (a) Informant Son
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 9/45 (month) (year)
(c) Cemetery or crematory Edge Hill Cem. Location Charles Town, W. Va.
18 (a) Funeral director John O. Mitchell
(b) Address 1900 Eutaw Place
19 (a) (Date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-6-45 19..., at 6:40 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 2-2 1945, to 2-6 1945, and that I last saw h[illegible] alive on 2-6 1945.
Immediate cause of death Cardio-Respiratory Failure — Duration
Due to Heart failure
Due to Hypertension
Other Conditions Pneumonia-lobar
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John D. Morris, M.D.
Address GMH. Date signed 2-8-45 M. D.

FEB 8 1945

VS 150

625630

625630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT IN WHITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 2 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 E. Monument St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Otto Dabney

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	Married

6 (b) Name of husband or wife Estella
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Dabney
13. Birthplace Virginia

MOTHER
14. Maiden Name Liza Wilson
15. Birthplace Virginia

16 (a) Informant Estella Dabney
(b) Address 1030 E Monument St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 11 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A. A. County Md.
18 (a) Funeral director Mrs. Robert A. Elliott & Dyt
(b) Address 1129 N. Caroline St.
19 (a) FEB 8 - 1945 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7 1945, at 1.45 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 1-21 1945, to 2-7-1945, and that I last saw h[im] alive on 2-7 1945.

Immediate cause of death	Duration
Carcinoma of Lung — primary site undetermined.	3 t yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Carcinoma of Lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature W. C. Ebeling III M. D.
Address University Hosp. Date signed 2-7-45

VS 150

625631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625631 Registered No. 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 127 N. Dallas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13-21?, 1923

8. AGE: Years: 21 | Months: -5- | Days: 14-22? | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Henry (d)
13. Birthplace ?

MOTHER
14. Maiden Name Bessie Gough
15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 10/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Frederick Road

18 (a) Funeral director Mrs Albert A. Ellis & Daughter
(b) Address N 29 N. Carrollton St.

19 (a) 1945 (Date rec'd by registrar) (b) Hampton Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1945, at 12:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 11, 1944 to Feb. 5, 1945, and that I last saw h in alive on Feb. 5, 1945.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 3 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leo Leibman M. D.
Address Baltimore Maryland Date signed 2-7-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

VS 150

G25632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 1310

G25632 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 N. Carolina St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 N. Carolina St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Myrtle Marie Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Walter Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1899

8. AGE: Years	Months	Days	If less than one day
46	2	27	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John W Glascoe

FATHER 13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Zoter P. Moore

MOTHER 15. Birthplace Balto. Md.

16 (a) Informant Walter Jones

(b) Address 1217 N. Carolina St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemetery

Location A A County Md.

18 (a) Funeral director Mrs. Robert A. Elliott & Daughter

(b) Address 1129 N. Carolina Street

19 (a) 2-8-1945 (b) Registered by registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5, 1945, at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1 1944 to 2/5 1945 and that I last saw h.e.r alive on 2/5 1945

Immediate cause of death Hypertensive cardio-renal disease (cardiac failure) — Duration unk.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Rayner Browne M. D.

Address 1500 E. Madison St Date signed 2-6-

Rayner Browne. X

G25633 BALTIMORE CITY HEALTH DEPARTMENT 93D G25633
CERTIFICATE OF DEATH Registered No.

The entries on this certificate should be carefully supplied and the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 822 S. Ellwood Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 ds
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 S. Ellwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Knight

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11-1866

8. AGE: Years	Months	Days	If less than one day
78	3 2	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business at Home

FATHER
12. Name John T. Knight
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Lennie E. Dolan
15. Birthplace Canada

16 (a) Informant E. Knight
(b) Address 822 S. Ellwood Ave

17 (a) Burial (b) Date thereof Feb 10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Road.

18 (a) Funeral director John A. Moran
(b) Address 3602 E. Balto. St.

19 (a) FEB 8 - 1945
(Date rec'd by registrar) Huntington White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 - 1945, at 7:40 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. B. McNally Res. Home Physician M.D.
Medical Examiner.
Date signed 2-7-45

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G26634

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3441 E. LOMBARD ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3441 E. LOMBARD ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM G. ECKSTEIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife NATHALIA ECKSTEIN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 23 1870

8. AGE: Years	Months	Days	If less than one day
74	2	14	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation RETIRED BRAKEMAN
11. Industry or business

FATHER
12. Name GEORGE ECKSTEIN
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARGARET STINER
15. Birthplace GERMANY

16 (a) Informant NATHALIA ECKSTEIN (WIFE)
(b) Address 3441 E. LOMBARD ST.

17 (a) BURIAL (b) Date thereof FEB. 10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) FEB 8 - 1945 (b) Thurlington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH FEB. 6 1945 at 12/30

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4-45 19__, to 2-6-45 19__, and that I last saw h~~im~~ alive on 2-5-45 19__.

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular Disease	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Costantino M.D.
Address 1-27 S. Conkling St Date signed 2-7-45

X

G25635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G25635

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 1400 N. Caroline

(b) Street address ~~416 N. Linwood Ave~~

(c) Hospital or institution: St. Joseph's Hosp.

(d) Length of stay in hospital or inst. (~~yrs.~~ or days) 39

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State ~~Balt~~ Md (b) County —

(c) City or town Balto. Md. (If outside city or town limits, write RURAL and give town)

(d) Street No. 416 N. Linwood Ave (If rural give location)

(e) Citizen of foreign country? Yes (Yes or No)

If yes, name country

3 (a) **FULL NAME** MICHAEL F. WOLLIN

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 215 07 1384

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife ELIZABETH

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 3 1883

8. AGE: Years	Months	Days	If less than one day
61	5	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Stand. Oil Co.

FATHER

12. Name EDWARD WOLLIN

13. Birthplace GERMANY

MOTHER

14. Maiden Name CATHERINE BATZ

15. Birthplace GERMANY

16 (a) Informant ELIZABETH WOLLIN (WIFE)

(b) Address 416 N. LINWOOD AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 9/45 (month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER

Location BELAIR ROAD

18 (a) Funeral director Lilly & Zeder Co.

(b) Address 403 S. POPLAR ST.

19 (a) FEB 8 1945 (Date rec'd by Registrar) Huntington Wills Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1945, at 9:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28-1944 to 2-5-1945 and that I last saw him alive on 2-5-1945.

Immediate cause of death Cardiac Failure — Duration

Due to Coronary Thrombosis

Due to Arteriosclerosis

Other Conditions Pulmonary Embolism.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Edward Scavone M. D.

Address Sta Josephs Hosp Date signed 2-5-45

G25636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63B

Registered No. 25636

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Eastern Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Gryszkiewicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Anthony

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business at Home

FATHER
12. Name Stanislaw Kalwa
13. Birthplace Poland

MOTHER
14. Maiden Name Stanislawa Lechert
15. Birthplace Poland

16 (a) Informant Anthony Gryszkiewicz
(b) Address 2211 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 10/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1930 Eastern Ave

19 (a) FEB 8 — 1945 (Date rec'd by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1945, at 10:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1945, to Feb 7 1945; and that I last saw her alive on Feb. 7 1945

Immediate cause of death	Duration
Chronic Myocarditis	4 yrs.
Pulmonary Edema	2 days
Due to Arteriosclerosis by Senility resulting with delayed treatment	4 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leo. J. Lipsey M. D.
Address 1218 Patterson Park Ave Date signed 2/8/45

G25637 Caroline L. Badart G25637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 800 Edgevale Road, City
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline L. Badart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edward J. Badart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 72? Months Days If less than one day hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: William James Sneeringer
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mary ?
15. Birthplace: ?

16 (a) Informant: Edward J. Badart
(b) Address: Mercy Villa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/45 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Md.

18 (a) Funeral director: H. W. Mears and Son
(b) Address: 805 N. Calvert St.

19 (a) Filed by (b) Registrar Huntingtown, Md. FEB 8 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 1945, at 11:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from January 7 1945, to February 7 1945, and that I last saw her alive on January 7 1945.

Immediate cause of death	Duration
Cardiorespiratory failure	
Due to Cerebral accident (Subdural hematoma)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Subarachnoid hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statis-

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. L. Zuercher M.D.
Address Mercy Hosp. Date signed 2/8/45

X

625638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

625638 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 N. Lakewood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 N. Lakewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles N. Allen

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-1889

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20th 1889

8. AGE: Years	Months	Days	If less than one day
55	5	18	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Conductor

11. Industry or business Balto. Transit Co.

FATHER
12. Name Thomas Allen
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Caroline Kommer
15. Birthplace Balto. Md.

16 (a) Informant Thelma Allen
(b) Address 405 N. Lakewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director E. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) FEB 8 1945 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7th 1945, at 7 40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1943, to Feb. 7 1945, and that I last saw him alive on Feb. 7 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 1 hr.
Due to Hypertension
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Lawhey
Address 444 S. Ellwood Ave. Date signed M 2 D 8 45.

G25639 — BALTIMORE CITY HEALTH DEPARTMENT — G25639 Registered No.

CERTIFICATE OF DEATH 48a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Hagerstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 31 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cecilia Marie Sammons

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Gordon W. Sammons
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 21, 1898

8. AGE: Years	Months	Days	If less than one day
46	1	17	hr. min.

9. Birthplace: Benwood, W. Va. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Wm. H. O'Connell
13. Birthplace: W. Va.

MOTHER
14. Maiden Name: Belle Cusick
15. Birthplace: W. Va.

16 (a) Informant: Mr. Gordon W. Sammons
(b) Address: 31 W. Franklin St., Hagerstown, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/8/45 (month) (day) (year)
(c) Cemetery or crematory: MOUNDSVILLE Cem.
Location: Moundsville, W. Va.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

FEB 8 1945 (b) (Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8 1945, at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24 1945, to 2/8 1945, and that I last saw her alive on 2/8 1945.

Immediate cause of death	Duration
Respiratory failure	12 hrs.
Due to Cardiac decompensation	9 days
Due to Rheumatic C.V. disease	
Other Conditions Malignancy of cervix	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Helen a Sammons M. D.
Address: Vets. Hospital Date signed 2/8/45

VS 150

Huntington Williams Phila

93c

G25640

46624.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G25640

Registered No. 1062

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town Washington - D.C.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1227 Gainma Place
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Irene Wilke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	married

6 (b) Name of husband or wife Samuel Wilken
6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) 1-10-10

8. AGE: Years	Months	Days	If less than one day
34.	-	28	..... hr. ..... min.

9. Birthplace W. Va
(Town, county, and state)
10. Usual Occupation Beautician
11. Industry or business

FATHER
12. Name Wiley Huggins
13. Birthplace W. Va.

MOTHER
14. Maiden Name Emma Dunham
15. Birthplace W. Va.

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 2/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location Washington, D.C.

18 (a) Funeral director Wm. R.F. Hines
(b) Address 2901 14th Street N.W. Washington D.C.

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

1945

VS. 350

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 - 1945, at 6.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan - 3 1945, to Feb - 8 1945, and that I last saw him alive on Feb - 8 1945.

Immediate cause of death Bronchiectasis
a. b ? pulmonary embolus

Duration: Years Minutes

Due to.....

Due to.....

Other Conditions Bronchopleural Fistula + Empyema
(Include pregnancy within 3 months of death)

Date of operation 1/18/45

Major findings of operation: Left Lower Lobectomy for Bronchiectasis

of autopsy:.....

2 1/2 months

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Alan C. Woods Jr.
Address John Hopkins Hospital Date signed 2/8/45

X

Under

625641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8/a

625641

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address... Hospital, Rd.
(c) Hospital or institution: Sydenham Hosp. Rd.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Bel. St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Andrew Shuler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lena F. Shuler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/18/82

8. AGE: Years 63 | Months 10 | Days 30 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Ormond Shuler
(b) Address 4113 Taylor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/43 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Anne Arundel Co

18 (a) Funeral director Forsaken Funeral Home
(b) Address 4401 Belair Rd

19 (a) (b) (Date received by registrar) Huntington Williams, M.D. Registrar

FEB 8 - 1943

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7/43 19~~43~~ at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/22 1943 to 2/7 1943, and that I last saw him alive on 2/7 1943.

Immediate cause of death	Duration
Respiratory Failure	
Due to Pneumonia, Staphylo. coccus	3 wks.
Due to Brain Abscess	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret K. D. Smith M. D.

Address Date signed 2-6-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G25642
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Frederick R.D. #1
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mt Pleasant
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amanda Cramer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed.

6 (b) Name of husband or wife George W. Cramer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1872

8. AGE: Years 72 | Months 7 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Thurmont, Md
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John A. Homer
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Ann Homer
15. Birthplace Maryland

16 (a) Informant John A. Cramer
(b) Address Baltimore Md

17 (a) Burial (b) Date thereof 2-12-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cem.
Location Frederick, Maryland

18 (a) Funeral director H. L. Echard
(b) Address Frederick, Md.

19 (a) (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

FEB 8 - 1945

Vs 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1945, at 1 07 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 1945 to 2-8 1945 and that I last saw her alive on 2-7 1945

Immediate cause of death Cerebral Hemmorrhage — Duration

Due to Hypertensive cardio-vascular disease

Due to

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. N. Garment M.D.

Address Univ. Hosp. Date signed 2/8/45

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

5643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

925

Registered No. 5643

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 226 S. Monastery Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 226 S. Monastery Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ann Meyd

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Francis Meyd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 18, 1876

8. AGE: Years 68 | Months 3 | Days 19 | If less than one day: hr. | 18 56 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Emil Schwakoff
13. Birthplace Maryland

MOTHER
14. Maiden Name ?
15. Birthplace Maryland

16 (a) Informant Miss Stella Meyd
(b) Address 226 S Monastery Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 9, 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. County, Md.

18 (a) Funeral director Geo. L. Schwab
(b) Address 2101 Frederick avenue

19 FEB 9 - 1945 (Date rec'd by registrar) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1945 at 6:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4th 1945 to Feb 6 1945; and that I last saw him alive on Feb 5 1945

Immediate cause of death: Myocardial insufficiency — Duration

Due to:

Due to:

Other Conditions: Arteriosclerosis Myocarditis
(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allen C. Schwenk M.D.

Address 1337 S. Charles St Date signed 2/6/45

G25644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G25644

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3413 Fairview Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3413 Fairview Avenue (If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Mary H. Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ---------- 1885

8. AGE: Years	Months	Days	If less than one day
60	---	---	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name William H. Green
13. Birthplace Maryland

MOTHER
14. Maiden Name Katherine Keenan
15. Birthplace Maryland

16 (a) Informant Mrs. Virginia G. L'Esperance
(b) Address 6 East Read Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meare & Son
(b) Address 805 N. Calvert Street

19 (a) FEB 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1945, at 6:35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to July 6 1945, and that I last saw h[illegible] alive on July 6 1945.

Immediate cause of death	Duration
Pulmonary Edema	
Fracture of Femur	
Due to Chronic Arthritis	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James A. Lazenby
Address [illegible] Medical Arts Date signed 2/9/45

625645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

✓ 625645 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D. 2
(e) Length of stay in Baltimore (yrs., mos., or days) 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 W. Perry Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Md

MOTHER
14. Maiden Name Nellie Cannon
15. Birthplace Md

16 (a) Informant Thomas Young
(b) Address 124 W. Perry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 11-45 (month) (day) (year)
(c) Cemetery or crematory [redacted]
Location [redacted]

18 (a) Funeral director James Stamos
(b) Address 1142 W. Pratt St

19 (a) (b) Huntington Williams, M.D. Registrar

Filed by Registrar FEB 9 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8, 1945, at 3:05 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Ulcerative Pulmonary Tuberculosis with Cavity Formation.

Due to

Other Conditions T.B. Peritonitis; T.B. Ulcers small intestine.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed February 8, 1945.

625646 Edna Knight

625646

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. S.S. 128-03-3602

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2917 W North St. 108 WARD)

2-FULL NAME Wm Russell Fletcher

(Residence in Baltimore: No. 2917 W. North Ave St.; 56 yrs., mos. da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 12.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. White

5-(STATE whether MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. April 10th, 1888 (Month) (Day) (Year)

7-AGE. 56 yrs. 9 mos. 26 da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Paper Carrier
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Clearfield Pa

PARENTS.

10-NAME OF FATHER. Frank Fletcher

11-BIRTHPLACE OF FATHER (State or Country). Pa. U S

12-MAIDEN NAME OF MOTHER Margaret Smith

13-BIRTHPLACE OF MOTHER (State or Country). Pa. U S

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Fletcher

(Address) 2917 W. North Ave

15- FEB 9 1945 Huntington Williams, M.D.
Signed ... 19... 19... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb 6, 1945 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1945, to Feb 6 1945, that I saw h living on Feb 6 1945, and that death occurred, on the date stated above, at 11 P. m. The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Alcoholism

(Duration) yrs. mos. da.

(Signed) David W. Hutchinson M. D.

Feb 6, 1945 (Address) 3009 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Pleasantville, N.J.	2/9/45 19...
20-UNDERTAKER WM. J. TICKNER & SONS	ADDRESS Balto., Md.

Important. See instructions on back of certificate.

X

647 ✓ G25647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1570

Registered No. YA-91885

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: BALTIMORE CITY HOSPITALS 2616

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 6718 Youngstown Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna Luca

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1944

8. AGE: Years	Months	Days	If less than one day
	4	23	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Italy

MOTHER
14. Maiden Name Josephine Meltese
15. Birthplace Italy

16 (a) Informant BALTIMORE CITY HOSPITALS (RECORDS)
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/45 (month) (day) (year)

(c) Cemetery or crematory Most Holy Redeemer
Location 4340 Belair Road

18 (a) Funeral director Joseph Fanace Inc
(b) Address 2013 Monument Ave

FEB 9 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8, 1945, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 31, 1945 to Feb. 8, 1945, and that I last saw h er alive on Feb. 8, 1945

Immediate cause of death Shock, surgical — Duration

Due to bowel surgery Leg meningococcic blood

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] M. D.

Address Baltimore City Hosp Date signed 2-8-45

X

625648 ✓ 625648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1706

Registered No. .....

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3614 E Lombard
(c) Hospital or institution: Johns Hopkins Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3614 E. Lombard Street
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME Louis Krause

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife .....
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 29-1935

8. AGE: Years	Months	Days	If less than one day
10 9	7	9	hr. ..... min. .....

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation S C Pool
11. Industry or business

FATHER
12. Name Martin Kraus
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elsie P. Burkins
15. Birthplace Baltimore

16 (a) Informant Martin Kraus
(b) Address 3614 E Lombard
17 (a) Burial (b) Date thereof Feb 9 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location City
18 (a) Funeral director Ullrich Funeral Home
(b) Address 2004-6 Eutaw St
19 (a) ..... (b) Huntington Williams
(Date of registration) FEB 9 1945 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7- 1945, at 4:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH ..... Shock.
Fractured 3rd lumbar vertebra
Due to .....
Other Conditions Fractured pelvis, laceration of bowels & bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-7- at 4:05 P.M.
(b) Where did injury occur Lombard & Conkling Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian, struck auto truck

23. Signature Howard J. Madeira M.D.
Medical Examiner
Date signed 2-8-45

G25647 | 111 ✓ G25643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

Every item of information should be carefully supplied. Please write plainly, with unfading ink. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 2 8 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 N. Broadway (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Virginia Mister
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Mar 30. 1880

8. AGE: Years 64 | Months 10 11 | Days 7 | If less than one day hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation HOME
11. Industry or business

FATHER
12. Name Stewart Webster
13. Birthplace Md

MOTHER
14. Maiden Name Alfarata Thomas
15. Birthplace Md

16 (a) Informant John Mister
(b) Address 1719 N Broadway

17 (a) Burial (b) Date thereof Feb 7 21 (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Baltimore Md

18 (a) Funeral director Wells & Funeral Home
(b) Address 2004 E Oliver St

19 (a) FEB 9 - 1945 (Date rec'd by registrar) (b) Huntington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7/45 19 11 16 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6/1945 to 2/7 1945 and that I last saw h[illegible] alive on 2/7 19 45.

Immediate cause of death Respiratory Failure — Duration
Due to Pneumonia
Due to Cerebral Hemorrhage
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Pneumonia

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmond Scavone
Address St. Joseph's Hosp Date signed 2/8/45

VS 150

625650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

Registered No. 625650

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County None
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4154 Falls Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1945

8. AGE: Years | Months | Days: 1 | If less than one day: 16 hr. 38 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Robert Taylor Jr.
13. Birthplace Maryland

MOTHER
14. Maiden Name Dorothy F. Buck.
15. Birthplace Maryland

16 (a) Informant Dorothy F. Taylor.
(b) Address 4154 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 9, 1945 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Taylor Ave

18 (a) Funeral director Chenoweth & Donovan
(b) Address 814-17 Eastern Ave

19 (a) FEB 9 1945 (b)
Registrar

VS 160

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1945, at 7.08 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/7/1945 to 2/7/1945, and that I last saw he alive on 2/7/1945.

Immediate cause of death Congenital pulmonary atelectasis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward C. Brown Jr. M.D.
Address M. Gen. Hosp. Date signed 2/8/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 12 a

Registered No. 625651

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 W 25th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 W. 25th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Margaut Loate.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow.

6 (b) Name of husband or wife Horatio M. Loate.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1874

8. AGE: Years	Months	Days	If less than one day
70	6	27	hr. min.

9. Birthplace Manchester, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jacob Baltozer.
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Sarah Fuhrman
15. Birthplace Maryland.

16 (a) Informant Margret R. Loate
(b) Address 211 W 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 10 1945 (month) (day) (year)
(c) Cemetery or crematory Manchester
Location Carroll Co, Md.

18 (a) Funeral director Jacob Wink Sons,
(b) Address Manchester, Md.

19 (a) FEB 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8, 1945, at 5 05 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 16 1944 to Feb 8 1945, and that I last saw h[illegible] alive on Feb [illegible] 1945

Immediate cause of death	Duration
Cerebral hemorrhage	2 dy
Due to Hypertension cerebr	6
Due to senile dementia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature [illegible] M. D.
Address 2427 Chesterfield Ave Date signed 2/9/45

G25652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G25652

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 N. Eden St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 N. Eden St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Maggie White

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Wm. H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 7, 1880

8. AGE: Years 64 | Months 10 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Va
(Town, ~~county,~~ and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Amanda Aytes
15. Birthplace Va

16 (a) Informant Mathew White
(b) Address 1212 N. Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph G. Dodd
(b) Address 1304 N. Central Ave

19 FEB 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5 1945 at 6 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1944 to Feb 5 1945, and that I last saw her alive on Feb 3 1945.

	Duration
Immediate cause of death Cerebral Hemorrhage	2 day
Due to Hypertensive Cardiac Vascular Renal disease ?	
Due to	
Other Conditions Arteriosclerosis	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. K. Adams M. D.
Address 2222 N. Caroline Date signed 2-8-45.

VS 3

625653

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 1213

Reg. Dist. No. .....

Dr Lally

625653

PLACE OF DEATH:

City 118 N Green St.

or town Baltimore Md

(If outside city or town limits, write RURAL and give nearest town)

long in above place of death? 6 years

pital, institution, or street address where death occurred: 6 years

long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 144 W Franklin St

(If rural, give LOCATION)

2.(a) If veteran, name war .....

(a) FULL NAME Frederick R Seager

3. (b) Social Security Number 213-18-3403

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

) Name of husband or wife .....

6.(c) If alive, give age ..... years

rth date of deceased (mo., day, yr.) Sept 19, 1902

AGE: Years	Months	Days	If less than one day
43	5	18	19 hrs. ..... min.

Birthplace Hagerstown

(Town, county, and state)

Usual occupation .....

Industry or business .....

12. Name Samuel E. Seager

13. Birthplace Hagerstown Md

14. Maiden name Anna Wachtel

15. Birthplace Hagerstown Md

Informant Mrs Beulah Williams

Address Hagerstown Md

Burial

rial, cremation, or removal. Which?) Date thereof Feb 9 1945

(month) (day) (year)

metery or crematory Rose Hill Cemetery

cation Hagerstown Md

neral director Andrew K Hoffman

dress Hagerstown Md

FEB 9 - 1945 Huntington Williams, M.D.

ate rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1945, at 1 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12 1945, to Feb 8 1945

and that I last saw h... alive on February 8 1945

Immediate cause of death Hepatic Cirrhosis — DURATION 2 Month

Due to .....

Due to .....

Other conditions Pulmonary Tuberculosis

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE L. G. Lally M.D.

M. D. or other

Address 3517 Edmondson Ave Date signed Feb 9, 1945

124

654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. 625654

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2800 Maisel St #30 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Balotin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife

6 (c) If alive, give age 1886

7. Birth date of deceased (mo., day, yr.) Oct 15 1886

8. AGE: Years	Months	Days	If less than one day
58	3	24	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant Melvin Balotin
(b) Address 3 E. Heath St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1739 E. Balto St

19 (a) FEB 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8-1945 at 800 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19-1945 to 2-8-1945 and that I last saw him alive on 2-8-1945

Immediate cause of death Cardiac Failure — Duration

Due to Progressive Thrombosis of coronary artery

Due to Coronary Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen C. Wooden M. D.
Address W.B.G.H. Date signed 2-8-45

VS 180

G25655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G25655

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2414 Liberty Heights
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2414 Liberty Heights (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Benjamin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Wolf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 80 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Leth (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Eli
13. Birthplace Leth

MOTHER
14. Maiden Name Keonj
15. Birthplace Leth

16 (a) Informant Wm. Goodwin
(b) Address 2414 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-45 (month) (day) (year)

(c) Cemetery or crematory Rosedale
Location Joe Levin Inc

18 (a) Funeral director Joe Levin Inc
(b) Address 1438 E. Baltimore St

19 (a) FEB 9 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8-45 19..., at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-5-1945 to Feb-8-1945, and that I last saw her alive on Feb-8-1945.

Immediate cause of death	Duration
Bronchio-Pneumonia	
Due to acute Pulmonary Edema	
Due to Cardiac Failure & General arterio-sclerosis	
Other Conditions Chronic Lymphatic Leukemia (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Herman Seidel M.D.
Address 2404 Eutaw Pl Date signed 2/10/45

VS 150

107

656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 655656

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Green Spring & Belvedere Ave

(c) Hospital or institution: Levindale

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days) 55yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Same. (If outside city or town limits, write RURAL and give town)

(d) Street No. 117 Greenspring & Belvedere Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ISIDORE MEYER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	W

6 (b) Name of husband or wife NELLIE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name –

13. Birthplace Russia

MOTHER 14. Maiden Name –

15. Birthplace Russia

16 (a) Informant FLORENCE CAPLAN

(b) Address 1909 W. LYNNS FALLS PKWAY

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-45 (month) (day) (year)

(c) Cemetery or crematory Balt. Hebrew

Location

18 (a) Funeral director Jacob Levin Inc

(b) Address 1431 E. Balto. St.

FEB 9 - 1945 Huntington Williams M.D.

(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1944, to 2-8 1945, and that I last saw h[illegible] alive on 2-8 1945.

Immediate cause of death Cerebral hemorrhage — Duration 2-8-45

Chr. card. vas. disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. Edmund Levin

Address Levindale Date signed 2/9/45

X

625657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13B

625657 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 433 N. Biddle Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 433 N. Biddle St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Carman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race colored

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife William Carman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 51 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Bryant.
13. Birthplace N. C.

MOTHER
14. Maiden Name ?
15. Birthplace North Carolina

16 (a) Informant William Carman
(b) Address 433 N. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary cemt.
Location Cedar Hill Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) ____ (b) ____ Registrar
Date rec'd by registrar FEB 9 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1945 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1945 to Feb 7 1945 and that I last saw h[illegible] alive on Feb 6 1945

Immediate cause of death	Duration
Pulmonary Phthisis	1
Due to	6
Due to	mo
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. N. Halstead M. D.
Address 1 W Fayette Date signed 2/11/45

Huntington Williams, M.D.

X

~~25658~~ BALTIMORE CITY HEALTH DEPARTMENT G25658

CERTIFICATE OF DEATH 1860 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2645 Maryland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2645 Maryland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia E. Grafton.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow.

6 (b) Name of husband or wife Wm. H. Grafton.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3 1854

8. AGE: Years	Months	Days	If less than one day
91	1	3	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Joseph Osborn
13. Birthplace Md.

MOTHER
14. Maiden Name ? Krentler.
15. Birthplace Pa.

16 (a) Informant Mrs Hattie Lyons
(b) Address 2640 Maryland

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Feb 9, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn.
Location Woodlawn, Md.

18 (a) Funeral director Chenoweth & Donovan
(b) Address 240-11 Chestnut Ave.

FEB 9 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Febry 6 1945, at 7.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945, to Feb 6 1945, and that I last saw h[illegible] alive on Feb 6 1945.

Immediate cause of death: (a) Bronchopneumonia — Duration: 6 days
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: None
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence February 1, 1945 at 6:30 A M
(c) Where did injury occur? Ballmore Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Fell down cellar stairs

23. Signature H G Davis M. D.
Address 2848 St Paul St Date signed 2/8/45

Approved by Thomas J. Mascis, M.D. X

625659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. 625653

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~2161 Chelsea Terrace~~
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo. 20 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2161 Chelsea Terrace.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME ~~John Henry Hennessy~~ William Leroy Joseph Hennessy

3 (b) If veteran, name war —

3 (c) Social Security Account No. 705-05-8460

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	M

6 (b) Name of husband or wife Marie G. Hennessy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1891

8. AGE: Years	Months	Days	If less than one day: hr.	min.
53	4	17		

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Clerk.
11. Industry or business B & O. R. R.

FATHER
12. Name John J. Hennessy
13. Birthplace Ireland.

MOTHER
14. Maiden Name Mary R. Newman
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. M. G. Hennessy
(b) Address 2161 Chelsea Terr.

17 (a) Burial (b) Date thereof 2/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem.
Location Hollywood, Balto.

18 (a) Funeral director Wm. J. Fickus & Son
(b) Address Balto., Md.

19 (Date received by local registrar) FEB 9 - 1945 (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8-45 19..., at 3 20 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 2-8-45 2nd 2/8/45, to 3 20 19..., and that I last saw h[illegible] alive on 2-8- 19 45.

Immediate cause of death	Duration
(a) Acc. Congestive Failure	
Due to Fatal Cerebral Embolism	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hanbach L. Bere M. D.
Address Date signed

VS 150

(OVER)

625660 625660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 931

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age if especially important. Use black ink. Do not use abbreviations. Do not use ditto marks. Do not leave any space blank. If unknown, say so. Do not use any supplies.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 Baker Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward W. Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1 ✓	215-09-6652 ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married ✓

6 (b) Name of husband or wife Helen M. Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/1892

8. AGE: Years	Months	Days	If less than one day
52	1	13	hr. min.

9. Birthplace Courtland, Ala.
(Town, county, and state)
10. Usual Occupation Office Manager
11. Industry or business Carey Sales & Service Co.

FATHER
12. Name James Brown
13. Birthplace Ala.

MOTHER
14. Maiden Name Unknown
15. Birthplace Ala.

16 (a) Informant Mrs. Helen M. Brown
(b) Address 2807 Baker St.

17 (a) Burial (b) Date thereof 2/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 FEB 9 - 1945 Huntington for Williams, M.R.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 8 - 1945, at 7:45 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wallerius M.D.
Medical Examiner.
Date signed 2-8-45

G25661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45 V

Registered No. G25661

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4110 Fernhill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4110 Fernhill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT LEE HART, JR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1906

8. AGE: Years	Months	Days	If less than one day
38	1	27	hr. min.

9. Birthplace Fredericksburg, Va.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Robert L. Hart
13. Birthplace Md.

MOTHER
14. Maiden Name Floy Bragdon
15. Birthplace Va.

16 (a) Informant Mr. P. A. B. Hoblitzel
(b) Address 910 W. University Pkwy.

17 (a) Burial (b) Date thereof 2/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) FEB 9 1945 Huntington Williams, M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1945, at 9:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1945, to Feb 7 1945, and that I last saw alive on Feb 6. 1945.

Immediate cause of death	Duration
Atelectasis left lung.	2 days.
Due to Epilepsy.	20 years
Due to Malnutrition	-
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Howard F. Warner
Address 2604 Garrison Blvd. Date signed 2-9-45

VS 150

Annie Mary M. Ruehl ✗ ✓ 625662

625662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 625662

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Beechfield Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Mary M. Ruehl
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28-1865

8. AGE: Years	Months	Days	If less than one day
79	7	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name John Ruehl
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Heerlein
15. Birthplace Germany

16 (a) Informant Wm F. Ruehl
(b) Address 1010 Beechfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.
18 (a) Funeral director J. B. Kilpatrick
(b) Address Baltimore, Md.

FEB 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6, 1945, at 7:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 1945 to 2/6 1945 and that I last saw her alive on 2/6 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral Hemorrhage	
Due to Hypertensive Cardio Vascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bryan M. D.
Address 2/6/1945 Date signed
St. Agnes Hosp ✗

625663 JOHN T. DAVIS ✓ 625663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. Underline the causes of death clearly and legibly. Physicians: please write the cause of death in the space where age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 N Schroeder
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 N Schroeder (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John T Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1884

8. AGE: Years	Months	Days	If less than one day
60	5	21	hr. min.

9. Birthplace Baltimore, Md.. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John T. Davis
13. Birthplace Md..

MOTHER
14. Maiden Name Mary —
15. Birthplace Md..

16 (a) Informant Cora Davis
(b) Address 514 N. Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 9, '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location
18 (a) Funeral director Katie R. Williams
(b) Address 322 N. Schroeder St Huntington Williams, Mgr.

FEB 9 1945 (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1945 at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1945 to Feb 5 1945.
and that I last saw him alive on Feb 3 19 45.

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular Disease	2yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Date signed 2/5/45

VS 150

625664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

625664 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 105 Weber St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 Weber St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George G. Williams

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Agnes Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10 - 1865

8. AGE: Years	Months	Days	If less than one day
79	9	29	28 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William J. Williams
13. Birthplace England

MOTHER
14. Maiden Name Margaret Whalen
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Agnes Williams
(b) Address 105 Weber St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 10 - 1945 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cemetery
Location 1300 Moreland Ave.

18 (a) Funeral director Elizabeth Harle Inc.
(b) Address 116 E. West St.

19 (a) FEB 9 - 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1945 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to Feb 9 1945 and that I last saw h alive on 19

Immediate cause of death	Duration
Arteriosclerotic Gangrene of both	2 weeks
Due to bowel obstruction	
Due to arteriosclerosis	
Other Conditions Hypostatic pneumonia	2 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joan Miller M.D.
Address 1225 N. Charles St. Date signed 2/9/45

VS 150

625665 ✓ 625665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 652

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 S. Montford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 701 S. Montford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pelagia F. Swiaczkowski
3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Michael L.
6 (c) If alive, give age 53 years
7. Birth date of deceased (mo., day, yr.) June 28 1892
8. AGE: Years 52 | Months 7 | Days 9 | If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Martin Nowak
13. Birthplace Poland

MOTHER
14. Maiden Name Ewa Kosinski
15. Birthplace Poland.

16 (a) Informant Michael L. Swiaczkowski
(b) Address 701 S. Montford Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 12 45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location German Hill Rd.
18 (a) Funeral director Martin W. Dugolis
(b) Address 7110 Belair Rd
19 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

FEB 9 1945

Val 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1945, at 6:10 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1945 to Feb 7 1945, and that I last saw h alive on Feb 7 1945.

Immediate cause of death Hypotension Pneumonia — Duration 2/5/45
Due to Addison's disease — 1/1944
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William J. Ryan M.D.
Address 801 N Kenwood Ave Date signed 2/9/45

X

625666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625666 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + 33rd
(c) Hospital or institution: Union Memorial 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1135 East Baltimore (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Russia

3 (a) FULL NAME MORRIS DORMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife SOPHIE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation BUILDER

11. Industry or business

FATHER 12. Name BENS.

13. Birthplace

MOTHER 14. Maiden Name GOLDIE

15. Birthplace

16 (a) Informant GERSON DORMAN

(b) Address 3406 ELLAMONT (OA)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-45 (month) (day) (year)

(c) Cemetery or crematory Wash. Rd

Location

18 (a) Funeral director Jack Lewis, Inc.

(b) Address 1439 E. Balto. St.

19 (a) (Signature of local registrar) (b) Huntington Williams, M.D. Registrar

FEB 9 - 1945

VS-181

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1945, at 6:35 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.

Date signed 2/9/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25667 Porter ✓ G25667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write carefully; accuracy is especially important. Typewriting would be preferable. The spaces must be carefully supplied. The "

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 816 Stoll St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 816 Stoll St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Wiley Poston

3 (b) If veteran, name war

3 (c) Social Security Account No. 241-14-3961

MEDICAL CERTIFICATION

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Minnie A Poston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3-1883

8. AGE: Years	Months	Days	If less than one day
64	8	4	hr. min.

9. Birthplace Waynesville N.C.
(Town, county, and state)
10. Usual Occupation Retired Painter
11. Industry or business Self

FATHER
12. Name Unknown
13. Birthplace Waynesville N.C

MOTHER
14. Maiden Name Alice Allison
15. Birthplace Waynesville N.C.

16 (a) Informant Mrs Hilda Goodwin
(b) Address 816 Stoll St (25)

17 (a) Burial (b) Date thereof Feb 10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or Crematory Holy Cross Cemetery
Location York Ritchie Highway (Franklyn)

18 (a) Funeral director Milton Schilling
(b) Address 3914 S. Hanover St (25)

FEB 9 - 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

20. DATE OF DEATH 2/7 1945, at 7 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Fedorowicz M.D.
Medical Examiner.
Date signed 2/7/45

VS 151

625668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104 Q

Registered No. 625668

Please answer questions carefully and correctly. The information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 859 McKim Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 859 McKim Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dennis William Barnett

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 4 1943

8. AGE: Years 2 | Months | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name William E. Barnett
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Florence E. Bevan
15. Birthplace Philadelphia Pa.

16 (a) Informant (Mother) Florence E. Barnett
(b) Address 859 McKim Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location

18 (a) Funeral director Elmer H. Dublin & Co.
(b) Address 924 E. Edgar Street

19 (a) ____ (b) Huntington Williams
(Operator's by registrar)

FEB 9 - 1945
VS-191

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9, 1945, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Upper Respiratory Infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester J. Lubinski, M.D. M.D.
PER: Howard J. Haeseler, M.D.
Medical Examiner.

Date signed February 9, 1945

G25669 | BALTIMORE CITY HEALTH DEPARTMENT | G25669

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 179 N. ALLENDALE St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 179 N. ALLENDALE St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE A. DONNELLY

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	White	MARRIED

6 (b) Name of husband or wife Richard A.
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Sept 28 1884

8. AGE: Years	Months	Days	If less than one day
60	4	11	hr. min.

9. Birthplace BALTIMORE Md
(Town, county, and state)
10. Usual Occupation H. WIFE
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Richard A. DONNELLY
(b) Address 179 N. ALLENDALE St

17 (a) BURIAL (b) Date thereof FEB 9 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location City

18 (a) Funeral director Peth & B. M Walter
(b) Address PRATT & STRICKER Sts

19 (a) (b) Huntington Baltimore, Md
Date received FEB 9 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1945, at 4 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/4 1945, to 2/8 1945, and that I last saw her alive on 2/8 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 5 days

Due to: Hypertensive Cardio-vascular Disease — 10 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address 3629 Edmondson Date signed 2/9/45 M. D.

625670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

625670
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 Husken Court. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joan Seymour

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black.	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-31-14

8. AGE: Years	Months	Days	If less than one day
30	5	9	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Racy Beulah
13. Birthplace Va.

MOTHER
14. Maiden Name Roselie Haines
15. Birthplace Va.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 2-12-45 (month) (day) (year)
(c) Cemetery or crematory Federalsburg
Location Federalsburg Md.

18 (a) Funeral director J. Frampton Sons
(b) Address Federalsburg Md

19 (a) Feb 9 1945 (Date received by registrar) (b) Registrar Huntington Williams, MD

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 1945 at 1.34 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-8 1945 to Feb-9 1945 and that I last saw h[illegible] alive on Feb. 9 1945.

Immediate cause of death: Respiratory failure — Duration: 10 hrs.
Due to: Diabetic coma & shock
Due to: Diabetes Mellitus
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Elliott J. Dickson M.D.
Address Johns Hopkins Hosp. Date signed 2/9/45

525671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. 525671

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2203 W. Baltimore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 W. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Giuseppina Cinquegrani

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16 1877

8. AGE: Years	Months	Days	If less than one day
67	11	22	hr. min.

9. Birthplace Cefalu Italy
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name late Michele Cinquegrani
13. Birthplace Italy

MOTHER
14. Maiden Name Maria F. Misita
15. Birthplace Italy

16 (a) Informant Salvatore Cinquegrani (Brother)
(b) Address 2203 W. Baltimore St.

17 (a) Burial (b) Date thereof Feb. 10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd. Balt. Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) Date received by registrar FEB 9 1945 Huntington Ave, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8-1945, at 5-30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-6 1945, to 2-8- 1945, and that I last saw h[illegible] alive on 2-7- 1945.

	Duration
Immediate cause of death Pulmonary Infarct.	3 days
Due to Valvular insufficiency	yrs.
Due to Arteriosclerosis + hypertension.	yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Damiano M. D.
Address Medical arts Bldg Date signed

VS 150

625672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131Q

Registered No. 625672

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Northwood Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4613 Northwood Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret L. Kelly

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Frank J. Kelly
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) January 2-1875
8. AGE: Years 70 | Months 1 | Days 5 | If less than one day: hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Housework

FATHER
12. Name James Sullivan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Kane
15. Birthplace Ireland

16 (a) Informant Rev. Francis J. Kelly
16 (b) Address 4613 Northwood Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-10-1945 (month) (day) (year)
17 (c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
18 (b) Address 1426 Light St.

FEB 9 - 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1945, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/18/1944, to 2/7/1945, and that I last saw her alive on 2/7/1945.

Immediate cause of death	Duration
Hypertensive cardio vascular renal disease....	?
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deitel M. D.
Address 1226 Hanover St. Date signed 2/8/45

VS 150

573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 1370 G25673 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type if possible. Street age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 da.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto. (b) County Kent
(c) City or town Rock Hall
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Baker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Susanna M. Baker

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 24 1873

8. AGE: Years 71 | Months 1 | Days 15 | If less than one day — hr. — min.

9. Birthplace Rock Hall Md.
(Town, county, and state)

10. Usual Occupation Retired Waterman

11. Industry or business

FATHER
12. Name James F. Baker
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Harper
15. Birthplace Md.

16 (a) Informant Susie Baker
(b) Address Rock Hall

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-45 (month) (day) (year)
(c) Cemetery or crematory Wesley Chapel
Location Rock Hall Md.

18 (a) Funeral director John E. Miller Inc
(b) Address 238 E. Oliver St

19 (a) 1945 (Date received by registrar) Hunting for Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Febr. 9th 1945 at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1945, to Febr 9 1945, and that I last saw h alive on 19

Immediate cause of death uremia

Due to benign prostatic hypertrophy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Kenneth M. Browne M. D.

Address Uni Hosp Date signed 2/9/45

3

X

625674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

625674 Registered No.

Every item of information should be carefully supplied. Please WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Please WRITE PLAINLY, WITH UNFADING INK. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1227 N. Eugene (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph S. Sturgeon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	M

6 (b) Name of husband or wife Sophia M. Sturgeon
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Nov. 6 - 1880

8. AGE: Years	Months	Days	If less than one day
64	3	2	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Night Watchman
11. Industry or business Baltimore Transit

FATHER
12. Name Charles Sturgeon
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Ursula Boettinger
15. Birthplace Md

16 (a) Informant Sophia M. Sturgeon
(b) Address 1227 N. Eugene Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 - 12 - 45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location North Ave. & Milleville

18 (a) Funeral director Jos. E. Oliver & Sons
(b) Address 2435 E. Oliver St

19 (a) 2-9-1945 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1945, at 2:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1945 to Feb 8 1945, and that I last saw him alive on Feb 7 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Pneumonia following 2nd Stage Prostatectomy	
Due to Post Benign Prostatec Hypertrophy.	
Other Conditions Hypertension, Chronic Arteriosclerosis, Diabetes	

(Include pregnancy within 3 months of death)

Date of operation Feb 5, 1945
Major findings of operation: Benign Prostatic Hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A M Bacon Jr. M. D.
Address St Josephs Hospital Date signed 2-8-45

VS 150

G25675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G25675 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: L. B. G. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 Johnson St.
(If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Pacy

3 (b) If veteran, name war

3 (c) Social Security Account No. 711-07-1758

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Lucille McKenzie 6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) 12/20/1883

8. AGE: Years	Months	Days	If less than one day
61	1	18	hr. min.

9. Birthplace Balto. (Town, county, and State)
10. Usual Occupation Helper Picture
11. Industry or business Undertaking

FATHER
12. Name William H. Pacy
13. Birthplace England

MOTHER
14. Maiden Name Amelia Kern
15. Birthplace Balto.

16 (a) Informant Lucille Pacy
(b) Address 1606 Johnson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Catonsville

18 (a) Funeral director John F. Hoffmann
(b) Address 1312 Light St.

19 (a) 1945 (Date received by registrar) (b) Huntington Willis Registrar M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8-1945 at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2-1945 to 2-8-1945 and that I last saw him alive on 2-8-1945

Immediate cause of death	Duration
Coronary Thrombosis	6 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. Krlich M. D.
Address 1213 Light St. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 a

G25676 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1246 Cliftview Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1246 Cliftview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Amelia Colligan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John L. Colligan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22nd 1878

8. AGE: Years	Months	Days	If less than one day
66	8	16	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Conrad Schaefer
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Thomas
15. Birthplace Balto. Md.

16 (a) Informant John L. Colligan
(b) Address 1246 Cliftview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/45 (month) (day) (year)
(c) Cemetery or crematory St. Matthews
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (b) (Signature of registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8th 1945, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1944, to Feb 8 1945, and that I last saw her alive on Feb 6 1945

Immediate cause of death	Duration
Myocardial Insufficiency	6 mo
Due to Brights disease	2 yrs
Due to Arteriosclerosis	1 yr
Other Conditions Dropsy	1 mo.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Dr. L. Summerour M. D.
Address 9858 Harford Rd Date signed 2/8/45

VS 150

625677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

✓ 625677

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1037 Cathedral Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph P. Sinnott

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife May 25th

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Attorney at Law

11. Industry or business Employed by Government

FATHER
12. Name Patrick W. Sinnott
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Henry
15. Birthplace Ireland

16 (a) Informant Mrs Katherine Wilson
(b) Address 1037 Cathedral St

17 (a) Burial (b) Date thereof 2/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) FEB 9 1945 (b) Huntington for Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8- 1945, at 12 45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 2-8-45

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25678 ✓ G25678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1949 Pearlman Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1949 Pearlman Place (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Y. LeVine

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Mary LeVine
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2/11/1896

8. AGE: Years	Months	Days	If less than one day
48	11	27	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Leverman
11. Industry or business B & O R. R.

FATHER
12. Name Max LeVine
13. Birthplace

MOTHER
14. Maiden Name Lillian Herzog
15. Birthplace

16 (a) Informant Mary LeVine
(b) Address 1949 Pearlman Place

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 2/12/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ U.S. National
Location ~~Street and No.~~ Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 E. Baltimore St

19 (a) FEB 9 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8th 1945, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 1945 to 2/8 1945, and that I last saw h alive on 19.

Immediate cause of death Coronary Thrombosis — Duration Sudden
Due to Arteriosclerosis — ?
Due to — ,
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Blum M.D.
Address 106 E. Preston Date signed 2/9/45

VS 150

625679 ✓ 625679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Registered No. .....

625679

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 D
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 2103 Eagle Street
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Francis J. Simms

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of ~~husband~~ or wife: Lillian Simms
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Dec 4th 1880
8. AGE: Years 64 | Months 4 | Days 4 | If less than one day ..... hr. ..... min.
9. Birthplace Va
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Stone Mason
FATHER 12. Name Frank Simms
13. Birthplace Va
MOTHER 14. Maiden Name Martha Lowe
15. Birthplace Va
16 (a) Informant Lillian Simms
(b) Address 2003 Eagle St.
17 (a) Burial (b) Date thereof 2/12/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.
18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St
19 (a) 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1945, at 8 30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH .....
Perforation of gastric ulcer with acute diffuse peritonitis
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Howard J. Thelen M.D.
Medical Examiner.
Date signed 2-8-45

VS 151

X

G25630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G25630 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please, write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood + Greene St
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Kentucky Ave, 13 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Kirkwood

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edna M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10 1894

8. AGE: Years 50 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace: Balto Maryland (Town, county and state)

10. Usual Occupation: Vice Pres - Md Cay Wheel Co.

11. Industry or business

FATHER
12. Name: Harry D. Kirkwood
13. Birthplace: Balto Maryland

MOTHER
14. Maiden Name: Cora Brooks
15. Birthplace: Balto Maryland

16 (a) Informant: Donald A. Kirkwood
(b) Address: 2217 Kentucky Ave

17 (a) Balto (Burial, ~~cremation, or removal~~) (b) Date thereof 2/13/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 217 St. Paul St

19 (a) (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1945, at 8 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from February 8 1945, to February 9 1945, and that I last saw h.i. alive on February 9 1945.

Immediate cause of death: Respiratory Failure — Duration

Due to: Hypertensive cardio-vaseular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Millard T. Thaland Jr M. D.

Address Date signed

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

625681 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2202 W. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Louise Daum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mr. Frederick Daum

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26th 1854

8. AGE: Years 90 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER 12. Name (Not Known) Rosenfeld

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name "

MOTHER 15. Birthplace "

16 (a) Informant Frederick W. Daum

(b) Address 503 Rossiter Ave

17 (a) Balto (Burial, cremation, removal) (b) Date thereof 2/10/45 (month) (day) (year)

(c) Cemetery or crematory Balto

Location " Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) FEB 9 1945 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7th 1945, at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Feb 7 1945 and that I last saw h[er] alive on Feb 7 1945.

Immediate cause of death	Duration
Myocardial insufficiency - Arterio sclerotic type Heart disease with congestive failure	several years.
Due to Generalized arteriosclerosis	
Due to	
Other Conditions Fracture of femur (left)	7 days.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 2/1/45 M
(c) Where did injury occur? 2202 W. Lexington (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no
(Specify type of place)
(e) Means of injury Slipped + fell

23. Signature W. Mitchell M. D.
Address 2901 Edmondson Ave Date signed Feb 7 1945

VS 150

Approved by Howard J. Malecio, M. D. X

G25682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G25682 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address RAYNER + DUKELAND AVE.
(c) Hospital or institution: WEST BALT. GEN. HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mths
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 E. Biddle St.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ELSIE Dorothea HARDING

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~ married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~: Vernon Harding

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) June 15th 1914

8. AGE: Years 30 | Months 7 | Days 23 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Charles Newton
13. Birthplace Md.

MOTHER
14. Maiden Name L. Laura Morgan
15. Birthplace Penna

16 (a) Informant Vernon H. Harding
(b) Address 601 E. Biddle St

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/12/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) [illegible] (b) [illegible]
(State registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1945 at 10:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/12 1944 to 2/8 1945, and that I last saw her alive on 2/8 1945.

Immediate cause of death CACHEXIA — Duration

Due to CARCINOMA OF CERVIX

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. M. Lilienfeld
Address West Balto. Gen Hosp. Date signed 2/8/45

VS 150

G25683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

Registered No. G25683

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1732 E. Oliver St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-6
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 E. Oliver St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

DOS

3 (a) FULL NAME William F. Ruckle

3 (b) If veteran, name war	3 (c) Social Security Account No. — —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-10-1907

8. AGE: Years	Months	Days	If less than one day
37	9	27	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Driver
11. Industry or business

FATHER 12. Name James E. Ruckle
13. Birthplace Phila Pa.

MOTHER 14. Maiden Name Margaret Penning
15. Birthplace Md.

16 (a) Informant Mrs George H. Cooper
(b) Address 1-13 E. 23rd St.

17 (a) Burial (b) Date thereof 2-10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave.

18 (a) Funeral director Randell E. Humphreys
(b) Address 1401 N. Broadway

FEB 10 1945 (Date received by Registrar) (Undertaker for Williams Hill)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7-45 19 , at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1944 to Feb 7 1945, and that I last saw h alive on Feb 6 1945.

Immediate cause of death Influenza and Lobar Pneumonia — Duration 21 days

Due to

Due to

Other Conditions Varicose Ulcer Left Leg. Portal Cirrhosis — 3 yr.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert C. Smelkinson M. D.
Address 2025 E. North Ave. Date signed 2/8/45

VS 150

(over)

33a

G25684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G25684 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write as carefully as possible; especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: Mercy Hospital 10-34
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 Linford Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Douglass

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20 1867

8. AGE: Years 77 | Months 6 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Mrs Lillie H Douglass

(b) Address 1005 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-45 (month) (day) (year)

(c) Cemetery or crematory Balto National

Location

18 (a) Funeral director C. Lee Alder

(b) Address 4647 York Rd.

19 (a) FEB 10 1945 (Date rec'd by registrar) (b) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1945; at 2 P. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Madeira M.D. Medical Examiner.

Date signed February 9, 1945.

625685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

625685 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2011 E. 30th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 E. 30th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sophia Schulze

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband or wife: Reinhard Schulze
6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) Dec 25th 1872

8. AGE: Years 72 | Months 1 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business At Home

FATHER
12. Name Henry A. Hercke
13. Birthplace Germany

MOTHER
14. Maiden Name Elise K. Siemon
15. Birthplace Germany

16 (a) Informant Reinhard Schulze
(b) Address 2011 E. 30th St.

17 (a) Burial (b) Date thereof 2/12/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

FEB 10 1945 (Date rec'd by registrar) (b) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8th 1945, at 6.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to Feb 8 1945; and that I last saw h[illegible] alive on Feb 8 1945.

Immediate cause of death (Coronary) Cardio Renal Dis. — Duration 2 1/2 yrs.
Due to (Coronary) Thrombosis. — 7 days.
Due to Coronary Dis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Meyer M.D.
Address 1501 E 33rd St Date signed 2/9/45.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... current age is especially important. Physicians: please write the ca... the causes of death clearly and legibly

VS 130

625686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 625686

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2657 Lehman st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAHNER, MAX

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Alma A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-26-1900

8. AGE: Years 44 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Driver

11. Industry or business Stock Yards

FATHER
12. Name John Lahner
13. Birthplace Germany

MOTHER
14. Maiden Name Margarit Stager
15. Birthplace Germany

16 (a) Informant Mrs Max Lahner
(b) Address 2657 Lehman st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md

18 (a) Funeral director George A Stalin
(b) Address Fulton & Fayette

19 (Registered by) FEB 10 1945 (Date received by registrar) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8 1945, at 5.01 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/5 1945 to 2/8 1945 and that I last saw h in alive on 2/8 1945.

Immediate cause of death Basilar Meningitis, type not determined

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elmer H Foran M. D.
Address Sinai Hospital Date signed 2/9/45

625687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

625687 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1513 Riverside Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 Riverside Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John C. Langeman

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	W.

6 (b) Name of husband or wife Mary Bennett.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7 1864

8. AGE: Years	Months	Days	If less than one day
80	10	3	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Ret. Eng.
11. Industry or business B & O. RR.

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Family
(b) Address 1513 Riverside Ave.

17 (a) Burial, (b) Date thereof 2-12-45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olive.
Location Frederick Md

18 (a) Funeral director J. McCauley
(b) Address 130 E. Fort Ave.

19 (a) FEB 10 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8 1945, at 3.20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3 1945, to 2-8 1945, and that I last saw h[illegible] alive on 2-7 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	5 days.
Due to Arteriosclerosis	2 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. C. Sullod M. D.
Address 707 E. Fort Ave. Date signed 2-9-45

X

G20688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G20688 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 435 E. Gittings St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 435 E. Gittings St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelmina Sommers.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W.

6 (b) Name of husband or wife John L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1856

8. AGE: Years	Months	Days	If less than one day
88	9	10	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Home.
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Family
(b) Address 435 E. Gittings St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 2-10-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Nat.
Location Frederick Ave.

18 (a) Funeral director J. L. McCauley
(b) Address 320 E. Fort Ave.

19 (a) (Date received by registrar) (b) Registrar Huntington Williams, M.D.

FEB 10 1945

Form 450

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1945; at 9.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944, to Feb 8 1945; and that I last saw her alive on Feb 1 1945.

Immediate cause of death	Duration
Arteriosclerosis	
Chr. myocarditis	
Due to old age	
Irantion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify to be underlined)
(e) Means of injury

23. Signature L. H. Barranco

Address 436 E Fort Ave Date signed 2/9/45 M.D.

G25689 BALTIMORE CITY HEALTH DEPARTMENT G25689

CERTIFICATE OF DEATH V157E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3011 Northern Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Meaite

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 25 44

8. AGE: Years	Months	Days	If less than one day
	1	13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Meaite
13. Birthplace Mass.

MOTHER
14. Maiden Name Lorraine Higgs
15. Birthplace W. Va

16 (a) Informant Next of Kin
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 10 45 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Old Frederick Rd

18 (a) Funeral director Charles E. Delseth
(b) Address Edmondson Ave

19 (a) (Date received by registrar) (b)

VS 150 FEB 10 1945 Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8, 1945, at 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12 27 1944 to 2 8 1945, and that I last saw him alive on Feb. 8 1945.

Immediate cause of death Anaplasma

Due to Congenital heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Patient Autopsy Etc.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Byron
Address St. Agnes Hosp Date signed 2/8/45 M.D.

625690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

625690 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 5 wks.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 S. GLOVER ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Sims

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 9 1945

8. AGE: Years | Months | Days | If less than one day: 4 hr. 40 min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name FRANCIS SIMS
13. Birthplace N.C.

MOTHER
14. Maiden Name CAROLINE MILLER
15. Birthplace BALTO. MD.

16 (a) Informant FRANCIS SIMS (FATHER)
(b) Address 507 S. GLOVER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 10/45 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Quinn, INC.
(b) Address 403 S. WOLFE ST.

19 FEB 10 1945 Huntington Williams M.D.
(Date rec'd by Registrar) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1945, at 4 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1945, to Feb 9. 1945. and that I last saw h\m alive on Feb. 9 1945.

Immediate cause of death	Duration
Atelectasis	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank L. Vanns, M. D.
Address St. Jos. Hosp. Date signed 2-9-45

X

625691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

625691 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Do not abbreviate. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 617 W. Lafayette Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 W. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME IRENE L. BELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Frederick Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1886

8. AGE: Years	Months	Days	If less than one day
58	3	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick Carroll
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Chew
15. Birthplace Md.

16 (a) Informant Mr. Frederick Bell
(b) Address 617 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co., Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) FEB 10 1945 (Date rec'd by registrar) Huntington Willi... M.D.

MEDICAL CERTIFICATION P

20. DATE OF DEATH Feb. 6, '45 19 , at 7:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 19 44 to 2/6 19 45
and that I last saw h alive on 2/6 19 45

Immediate cause of death Cardio-Renal — Duration 3 Mo

Due to — Duration

Due to — Duration 1

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Hatcher
Address 1 x Date signed 2/8/45

VS 150

G25692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G25692 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully enrolled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution:
Church Home & Hospital 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1321 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WARD, MR. JOHN H.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	WIDOWED

6 (b) Name of husband or wife MARY E. WARD

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-2-1854

8. AGE: Years	Months	Days	If less than one day
91	1	7	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Painter, retired

11. Industry or business Penna. R.R.

FATHER 12. Name William T. Ward

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Cromwell, Debra M.

MOTHER 15. Birthplace Maryland

16 (a) Informant Miss Edith Scott

(b) Address 1321 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto., Md.

18 (a) Funeral director Wm. J. Dykeman & Son

(b) Address Balto., Md.

19 (a) FEB 10 1945 (b) Registrar
Date received by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-9 1945, at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 1945 to 2-9 1945 and that I last saw him alive on 2-9 1945

Immediate cause of death Bronchopneumonia — Duration 2

Due to Debilitation — Duration Age?

Due to Hypertensive cardiovascular renal disease, arteriosclerotic cardiovascular disease — Duration ?

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Thomas Hatch, M. D.
Address Church Home Hospital Date signed 2-9-45

Huntington Williams, M.D.

93D

G25693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G25693 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1617 John St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 John St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GERTRUDE DONNELLY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1877

8. AGE: Years	Months	Days	If less than one day
67	4	11	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name William Charles Donnelly
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Jennie Geddes
15. Birthplace Balto., Md.

16 (a) Informant Miss Letitia Donnelly
(b) Address 1617 John St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 9 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8, 1945 at 9:00 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1-45 to Feb 8/45 and that I last saw h[illegible] alive Feb 7/45

Immediate cause of death: Coronary Thrombosis — Duration: Few Weeks
Due to: Cardio Sclerosis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Stanley C. Hauck, M.D.
Address 1629 Mt. Royal Terrace Date signed 2/9/45

625694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55B

625694 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
Elmhurst Nursing Home 15-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 Rosedale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE AUGUSTA BROWN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife John Wesley Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1867

8. AGE: Years	Months	Days	If less than one day
77	8	19	hr. min.

9. Birthplace Carroll Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John J. Abbott
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Lucinda Armacost
15. Birthplace Carroll Co., Md.

16 (a) Informant Mrs. Amy E. Brown
(b) Address 2944 Winchester St.

17 (a) Burial (b) Date thereof 2/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) (b)
(Date rec'd by Registrar) Registrar

FEB 10 1945

Huntington Williams, M.D.

V.S. 490

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1945, at 5:06 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1944 to Feb 7 1945 and that I last saw her alive on Feb 7 1945

Immediate cause of death Chronic Cardiac Renal Dis. — Duration

Due to

Due to

Other Conditions Sclerosis of Spine

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest R. Latini

Address 1735 Pop Gr St Date signed 2/9/45

131a

G25695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G25695

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5805 Berkeley Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5805 Berkeley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH BLANCHE MERING

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles L. Mering
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 28, 1866

8. AGE: Years	Months	Days	If less than one day
78	10	10	hr. min.

9. Birthplace Carroll Co., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Albert Ecker
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Mary R. O'Dell
15. Birthplace Balto. Co., Md.

16 (a) Informant Mr. Chas. Ridgely Mering
(b) Address 5805 Berkeley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 10 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Feb. 8, 1945 at 3:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to Feb 8 1945.
and that I last saw h alive on Feb 7 1945

Immediate cause of death	Duration
Arteriosclerotic heart disease	10 yrs.
Due to	
Due to	
Other Conditions Cerebral hemorrhage	1 week

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Ecker M.D.
Address 6 Feb 9 1945 Date signed

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63 B

625696 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3010 Elgin Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3010 Elgin Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CECELIA PAULINE GORSUCH

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: E. Alfred Gorsuch
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Jan. 6, 1882
8. AGE: Years 63 | Months 1 | Days 1 | If less than one day hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Maximilian Biederman
13. Birthplace: Switzerland

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mr. E. Alfred Gorsuch
(b) Address: 3010 Elgin Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/45 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem. Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1945, at 3:00P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to Feb 7 1945, and that I last saw h[er] alive on Feb 6 1945.

Immediate cause of death: Thyro Toxic Heart Disease
Coronary Intervalvular
Due to: Heart failure
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: 6 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Sol Smith
Address: 1223 E. North Balto 2 Md. Date signed 2/9/45 M. D.

VS 150

625697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. 625697

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1628 E.Oliver Street
(c) Hospital or institution:

8-6

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 E.Oliver Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Paul Trainor

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary A.Brady
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Jan. 16th, 1867

8. AGE: Years 78 | Months 0 | Days 22 | If less than one day ###### min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired City Employee

11. Industry or business

FATHER
12. Name John P.Trainor
13. Birthplace Ireland

MOTHER
14. Maiden Name Martha Woods
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mary A.Trainor (Wife)
(b) Address 1628 E.Oliver Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12, 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue

18 (a) Funeral director George J.Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) FEB 10 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-30 1945 to 2-8 1945 and that I last saw him alive on 2-8 1945.

Immediate cause of death: Cerebral Arteriosclerosis — Duration 5 yrs

Due to:

Due to:

Other Conditions: Prostate Hypertrophy — 2 days

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Miller M. D.
Address 1700 N Edwards Date signed 2/9/45

97

~~25698~~ BALTIMORE CITY HEALTH DEPARTMENT 83a Registered No. 25698

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 Wilmslow Road
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Wilmslow Road
(e) Citizen of foreign country? no (If rural give location) (Yes or No)
If yes, name country

3 (a) FULL NAME Lidie Jane Orem

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: William L. Orem
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1860

8. AGE: Years 84 | Months 4 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Thomas K. Boland
13. Birthplace England

MOTHER
14. Maiden Name Ruth Ann Pyle
15. Birthplace ?

16 (a) Informant Rita Orem Billingslea
(b) Address 506 Wilmslow Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Greenmount
Location Greenmount Ave. & Oliver St.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) ... (b) ...

FEB 10 1945 Hutzler for Wilmer M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1942 to Feb 8 1945 and that I last saw her alive on Feb. 7, 1945

Immediate cause of death	Duration
Cerebral hemorrhage	3 days
Due to Cerebral and general arteriosclerosis	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature W. H. Smith M. D.
Address 3429 Chestnut Ave. Date signed

W H. Smith X

625699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 625699

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3405 Dudley Avenue
(c) Hospital or institution: 2623

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 84 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3405 Dudley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE ELIZABETH YINGLING

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: William Yingling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/20/1860

8. AGE: Years 84 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name ? weber
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. William Yingling
(b) Address 3405 Dudley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-10-45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (Registered by registrar) FEB 10 1945 Huntington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1945, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1945 to Feb 7 1945, and that I last saw her alive on Feb 6 1945

	Duration
Immediate cause of death: Coronary occlusion	
Due to: Chronic myocarditis	
Due to: Chronic Nephritis	
Other Conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 3001 Sherwood Ave Date signed Feb 9 45

VS 150

G25700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55d

G25700 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1717 Braddish Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 Braddish Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Sands

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age 17 years

7. Birth date of deceased (mo., day, yr.) Apr 7, 1928.

8. AGE: Years 16. | Months 9 | Days 23. | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation School girl

11. Industry or business

FATHER
12. Name John E. Sands
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary F. Spitzer
15. Birthplace Midland, Md.

16 (a) Informant Mr. John E. Sands
(b) Address 1717 Braddish Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Road

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St.

19 (a) (Local Registrar) Washington Williams M.D. Registrar
FEB 10 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 9th 1945 at 2:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to Feb 9th 1945 and that I last saw h[illegible] alive on Feb. 8th 1945.

Immediate cause of death Papillary carcinoma — Duration 6 mos.
Due to —
Due to (a) —
Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation Oct 15th 1944
Major findings of operation: Papillary carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. McDermott M.D.
Address 1136 Poplar Grove St Date signed 2/10/45 M. D.

X

The item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT USE RUBBER STAMPS, WITH UNFADING INK.

G25701

468186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G25701 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5+
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 118 N. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lucille Gorham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black.	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-4-02

8. AGE: Years	Months	Days	If less than one day
42	11	3	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Home keeper
11. Industry or business

FATHER 12. Name Cornelius Tillery
13. Birthplace N. C.

MOTHER 14. Maiden Name Maggie Hunter
15. Birthplace N. C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Thos. A. Wilson
(b) Address 1000 Pennsylvania Ave

FEB 10 1945 (Date rec'd by Registrar) (b) Huntington, W. Va.

MEDICAL CERTIFICATION A

20. DATE OF DEATH Feb-7- 1945 at 4.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-31 1945 to Feb 7 1945 and that I last saw her alive on Feb-7 1945.

Immediate cause of death: Uremia — Due to (a) Hypertensive cardiovascular disease
Due to (b) arteriolosclerotic nephritis
Other Conditions
(Include pregnancy within 3 months of death)

Duration: (a) 1 wk. (b) (c) (d)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William J. Dilley
Address Johns Hopkins Hospital Date signed 2/9/45

VS 150

G25702 467927

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

G25702 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 E. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jessie Simpson.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Clarence Simpson
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 7-3-06

8. AGE: Years 38. | Months 7 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Jas. Cornwall
13. Birthplace N. C.

MOTHER
14. Maiden Name Rottie Jaggers
15. Birthplace N. C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/45 (month) (day) (year)
(c) Cemetery or crematory
Location Chester, S. C.

18 (a) Funeral director Elroy Wilson
(b) Address 1000 Brantley

19 (a) FEB 10 1945 (Date rec'd by registrar) Hunting for William [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7- 1945 at 9.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-26 1945 to Feb. 7 1945, and that I last saw him alive on Feb 7 1945.

Immediate cause of death	Duration
Respiratory failure	Duration unknown
Due to Hypertensive Cardiovascular	
Due to Disease Cardiac failure	2 wks
Other Conditions Chronic Glomerulo-nephritis	

(Last three to be reported with months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
Signature William J. Dorsey Johns Hopkins Hosp. Date signed 2/8/45

X

VS 150

625703
466 111

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 30 c

Registered No. 625703

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 923 McElderry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Preston
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife Madeline
6 (c) If alive, give age 26 years
7. Birth date of deceased (mo., day, yr.) 5-14-07
8. AGE: Years 37. | Months 8 | Days 25 | If less than one day hr. min.
9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER
12. Name Bob Preston
13. Birthplace S. C.

MOTHER
14. Maiden Name Liana ? ?
15. Birthplace S. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location
18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Edmondson Ave
(c) Date filed by registrar FEB 20 1945 Henrietta Lee Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 - 1945 at 12.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22 1944 to Feb. 9 1945, and that I last saw him alive on Feb. 9 1945.

Immediate cause of death Respiratory failure — Duration
Due to B Wassermann infection of brain
Due to Cerebro spastic paraplegia due to syphilis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Cellulitis of buttocks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. Kattus
Address Johns Hopkins Hosp. Date signed 2/10/45

VS 150

G25704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G25704
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 310 N. Ann St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jean Coleman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-30-44

8. AGE: Years	Months	Days	If less than one day
	2.	8	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Coleman
13. Birthplace S. Ca.

MOTHER
14. Maiden Name Lena Lansby
15. Birthplace S. Ca.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1845 Brightley Ave

19 (a) (Date rec'd by registrar) (b) Huntington Nellis Lynch, M.D. Registrar

FEB 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1945 at 9.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 8 1945 to Feb 8 1945 and that I last saw h[illegible] alive on Feb 8 1945

Immediate cause of death Bronchopneumonia — Duration ± 1 wk

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

C. Signature Ruth Whedbee M. D.
Address Johns Hopkins Hosp Date signed 2/13/45

VS 150

G25705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 H Registered No. G25705

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 Alceanna Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard O. Edwards

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
35			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Removal (b) Date thereof 2/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Albion
Location Albion Md

18 (a) Funeral director Wilson Ford Doe
(b) Address 1217 E Fort Ave

19 (a) FEB 10 1945 (b) Huntington-Williams Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1945; at 6:42 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating Gas.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-9-45 at 6:30 A. M.
(b) Where did injury occur? 1717 Alceanna Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no.
(d) Means of injury Open gas burners on kitchen gas stove.

23. Signature Howard J. Mendes M.D.
Medical Examiner.
Date signed February 9, 1945.

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 25706

~~25706~~ 124a

Please write the causes of death clearly and legibly. Typewriter, if available, preferred. Please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3126 Barclay Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John T. Magee (Mc Gee)

3 (b) If veteran, name war	3 (c) Social Security Account No.
W W I	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1895

8. AGE: Years	Months	Days	If less than one day
49	10		hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Sanford Mc Gee
13. Birthplace S. C.

MOTHER
14. Maiden Name Sarah E. Harrison
15. Birthplace S. C.

16 (a) Informant Auris C. Mc Lee
(b) Address 2127 madison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount S.C.
Location S.C.

18 (a) Funeral director George G. Kelson
(b) Address 1303 Presstman St

19 (a) FEB 10 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8- 1945, at 10 40 AM

21. I certify that I took charge of the remains described above, held an autopsy & inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH..... Acute Fatty degeneration of Liver

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Homer J. Muldeis M.D.
Medical Examiner.
Date signed 2-8-45

X over

G25707 ✓ G25707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2200 ROSLYN AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 ROSLYN AVE (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME ALLEN H. WENTZ

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife CARRIE M. WENTZ
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) JULY 26, 1858

8. AGE: Years	Months	Days	If less than one day
86	6	14	....hr. ....min.

9. Birthplace HANOVER, PA. (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name VALENTINE WENTZ
13. Birthplace PA.

MOTHER
14. Maiden Name ADELINE ORR
15. Birthplace PA.

16 (a) Informant MRS. CARRIE M. WENTZ
(b) Address BALTIMORE, MD.

17 (a) Burial (b) Date thereof 2/12/45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE CEM.
Location PIKESVILLE, MD

18 (a) Funeral director J. FRANCIS REESE
(b) Address WESTMINSTER, MD.

19 (a) FEB 14 1945 (Date rec'd by registrar) (b) Funeral Director Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 9 1945, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16 1944, to 2/9 1945, and that I last saw him alive on 2/3/ 1944.

Immediate cause of death	Duration
Coronary occlusion	5 hrs.
Due to Advanced arterio-sclerosis	About 10 yrs.
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due ~~to external causes~~, fill in the following:
(a) Accident, suicide, ~~or homicide~~
(b) Date of occurrence
(c) Where did injury occur? (~~City or town~~) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter Dreibelbis M. D.
Address 2220 Garrison Blvd. Date signed 2/10/45

VS 2

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G25708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G25708 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3402 Lynchester Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marcia Rose Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Meyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Moisha Lurie
13. Birthplace Poland

MOTHER
14. Maiden Name Rachael ?
15. Birthplace Poland

16 (a) Informant Mrs Isaac Adleberg
(b) Address 3402 Lynchester Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Sharrei Zion Cemetery
Location Hamilton Ave Rosedale

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W. North Ave

FEB 1 1945 (Date filed by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-9 1945 at 9:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16 1945 to 2-9 1945 and that I last saw her alive on 2-8 1945

Immediate cause of death Metastatic Carcinomas

Due to Metastatic Ca

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1/10/45

Major findings of operation: Ca

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David S. Gordon M. D.
Address Sinai Hospital Date signed 2-9-45

625709 ✓ 625709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3747 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** EPSTEIN, SAMUEL

3 (b) If veteran, name war .....

3 (c) Social Security Account No. 217-14-9491

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Dena

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
78			hr. ..... min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation .....

11. Industry or business Tailor

FATHER
12. Name Meyer David Epstein
13. Birthplace Russia

MOTHER
14. Maiden Name Rose ?
15. Birthplace Russia

16 (a) Informant Mr Ellis A, Epstein
(b) Address Cordova Apts D. 1

17 (a) Burial (b) Date thereof Feb, 11, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Shaarei Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) ..... (b) ..... Registrar
(Date received by registrar) Clayton Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1945 at 10 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/26 1945, to 2/9 1945, and that I last saw h.im alive on ~~2/9~~ 2/8 1945.

Immediate cause of death ..... Duration

Coronary Heart Disease

Due to .....

Due to .....

Other Conditions Benign Prostate Hypertrophy

(If female pregnancy within 3 months of death)

Date of Operation 2/6/45

Major findings of operation: Benign Prostate Hypert

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Elmer Hoffman M.D.

Address Sinai Hospital Date signed 2/9/45

62571D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

62571D
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Ch
correct age is especially important. Physicians: please write the cau
e causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1133 E Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Stone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Zelda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
67 66			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Bakery Business

FATHER
12. Name Morris Max Stone
13. Birthplace Russia

MOTHER
14. Maiden Name Esther ?
15. Birthplace Russia

16 (a) Informant Morris Stone
(b) Address 1133 E Lombard St

17 (a) Burial (b) Date thereof Feb, 11, 1948
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel Cem
Location German Hill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7 1945, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1945, to 2/7 1945, and that I last saw him alive on 2/7 1945.

Immediate cause of death Cardiac Resp Failure — Duration

Due to Hypertension, Cardio-Vascular Disease

Due to Essential Hypertension

Other Conditions Pons Brain Tumor

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Simson M. D.
Address Sinai Hospital Date signed 2/7/45

FEB 12 1948

Washington Hollinger, MD

6

X

G25711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30

G25711 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address. Monument St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 59 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3834 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISRAEL LEVIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: ~~married~~ Widower

6 (b) Name of husband or wife: Ray

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 75 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Chaim

FATHER 13. Birthplace Russia

MOTHER 14. Maiden Name Bessie

MOTHER 15. Birthplace Russia

16 (a) Informant Hyman Resnick

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-45 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Location Balto Md

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 E. Baltimore St

FEB 10 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10-1945, at 2:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3 1945 to 2-10-1945 and that I last saw him alive on 2-10-1945

Immediate cause of death – Mesenteric Thrombosis

Due to Aortic Aneurysm

Due to –

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Aortic aneurysm & Mesenteric thrombosis

Duration

PHYSICIAN

Underline the cause to which death should be referred statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward S Gordon M. D.

Address Sinai Hospital Date signed 2-11-45

(over)

G25712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G25712 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution: Mt Sinai Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4613 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Jennie Appleton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Carl Yankeloff
13. Birthplace Russia

MOTHER
14. Maiden Name Baily
15. Birthplace Russia

16 (a) Informant Joshua Appleton
(b) Address 2801 Springhill Ave

17 (a) Burial (b) Date thereof 2-11-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Herring Run
Location Philad & Bowley's Lane

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto

FEB 10 1945 (b)
(Date received by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10th 1945 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19 1934 to Feb. 9th 1945, and that I last saw h[illegible] alive on Feb. 9 1945.

Immediate cause of death	Duration
arterio Sclerosis	1934
Chr. Nephritis	1940
Due to Chr. myocardial insufficiency	1934
Due to	
Other Conditions acute Coronary thrombosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Michelson M. D.
Address 2230 Eutaw Pl. Date signed 2/10/45

G25713

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13a

G25713 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1307 Etting St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Etting St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John Tyler Tisdale

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	married

6 (b) Name of husband or wife Deborah Tisdale
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1869

8. AGE: Years	Months	Days	If less than one day
75	10	13	hr. min.

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name John T. Tisdale
13. Birthplace Va

MOTHER
14. Maiden Name Ellen Brown
15. Birthplace Va

16 (a) Informant Deborah Tisdale
(b) Address 1307 Etting St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 - 11 - 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary cem
Location Md

18 (a) Funeral director George H. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (Date received by Registrar) (b) Registrar

FEB 10 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8- 1945, at 1 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 19, 1945, to Feb. 8, 1945, and that I last saw him alive on Feb 8, 1945.

Immediate cause of death Hypertensive Cardio-Renal Disease — Duration 2 yrs.
Due to
Due to
Other Conditions Bronchial Pneumonia
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice Adams M. D.
Address 312 E 23rd St Date signed 2-10-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25714 ✓ G25714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 728 Washington Blrd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 728 Washington Blrd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosario Villanti

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Married

6 (b) Name of husband or wife Santa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23 1877

8. AGE: Years	Months	Days	If less than one day
67	6	16	hr. min.

9. Birthplace Gioiosa Marca-Messina Italy (Town, county, and state)
10. Usual Occupation Trucker
11. Industry or business Baltimore Ohio

FATHER
12. Name late Salvatore Villanti
13. Birthplace Italy

MOTHER
14. Maiden Name Anna Buzzanca
15. Birthplace Italy

16 (a) Informant Santa Villanti (Wife)
(b) Address 728 Washington Blrd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Brault Bella Vue
(b) Address 52 N. Morley St.

19 (a) FEB 11 1945 (Date received by registrar) (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1945, at 8 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7, 1945 to Feb. 7, 1945 and that I last saw him alive on Feb. 7, 1945

Immediate cause of death	Duration
Acute Myocardial Failure	1 Day
Due to Chronic Bronchial Asthma	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank N. Oden M. D.
Address 2701 N. Calvert St. Date signed Feb. 10, 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

~~60-3715~~ 10-[illegible]5

✓ 62715 Registered No. 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 McCulloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

14 ✓

3 (a) FULL NAME Louise Langston or Louise Lauston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Davey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1912

8. AGE: Years	Months	Days	If less than one day
32	9	27	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business Druid Hill Laundry

FATHER
12. Name James Gill
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mary Massenburg
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 1940 Eastern Avenue

17 (a) [illegible] (Burial, cremation, or removal) (b) Date thereof 2-11-45 (month) (day) (year)
(c) Cemetery or crematory Raleigh, N.C.
Location
18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave
1-1-1945
19 (a) (Date rec'd by registrar) (b) Huntington Willi[illegible] Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH February 9, 1945 at 12:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28, 1944 to Feb. 9, 1945. and that I last saw h[illegible] alive on Feb. 9, 1945.

Immediate cause of death: Pulmonary Tuberculosis, ulcerations — Duration 6 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harold Hallow
Address Balto City Hosp. Date signed 2/10/45 M. D.

VS 150

AB-90713 G25716

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G25716 ✓ Registered No. 309

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos- 18days
(e) Length of stay in Baltimore (yrs., mos., or days) 22yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 349 Canal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sylvester Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mamie (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18-1900

8. AGE: Years 45 | Months - | Days 16 14 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Maria Thomas
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave,

17 (a) Burial (b) Date thereof 2/13/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary cem.
Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) FEB 111 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2- 19 45, at 10.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-17- 19 44, to 2-3- 19 45, and that I last saw h im alive on 2-3- 19 45.

Immediate cause of death	Duration
Pulmonary Hemorrhage	5 minutes
Due to Pulmonary Tuberculosis	?
Due to	
Other Conditions Leu.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Schwartz M. D.

Address Baltimore City Hosp Baltimore Md Date signed 2-5-45

VS 150

136

G25717 ✓ G25717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.D.O.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 156 Calvin St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME George Scott, Jr. ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/5/45

8. AGE: Years | Months: 1 | Days: - | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name George Scott
13. Birthplace ?

MOTHER
14. Maiden Name Katherine Rau
15. Birthplace Cambridge, Md.

16 (a) Informant Mary Brown
(b) Address 166 Oliver Street

17 (a) Burial (b) Date thereof 2/10/45 (month) (day) (year)
(burial, cremation, or removal)
(c) Cemetery or crematory Mt. Calvary Cemt.
Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date received by local registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1945, at 9.50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobular Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Preston M.D.
Medical Examiner.
Date signed 2-5-45

X

Please write the causes of death clearly and legibly. Physicians: please write as completely as possible. Space is especially important.

625718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

625718
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 449 Orford Ct
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 449 Orford Ct (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Coates

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife Abraham Coates
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Robinson
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Mary Washington
15. Birthplace Md.

16 (a) Informant Elizabeth Huskins
(b) Address 449 Orford Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 11, '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 11 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1945, at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945, to Feb 6 1945.
and that I last saw h alive on 19

Immediate cause of death
Cerebral Thrombosis
Due to Arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

Duration
2 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 2/9/45

Rs 150

[redacted] 625719 BALTIMORE CITY HEALTH DEPARTMENT 1937 [redacted] Registered No. 625719

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 A
(e) Length of stay in Baltimore (yrs., mos., or days) 10 A

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4306 Falls Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES H. ALDER

3 (b) If veteran, name war

3 (c) Social Security Account No. [redacted]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Mary M Alder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15 1853

8. AGE: Years	Months	Days	If less than one day
91 92	7	24	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Wm Alder
13. Birthplace Md.

MOTHER
14. Maiden Name Ophelia Getty
15. Birthplace Md.

16 (a) Informant Grace D. Bayly
(b) Address 4306 Falls Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 13 1945 (month) (day) (year)
(c) Cemetery or crematory St Marys
Location Hampden

18 (a) Funeral director Kenworthy & Duncan
(b) Address 3615-17 Chestnut Ave.

19 (a) FEB 1 1945 (Date received by registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1945, at 3:20 A M

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L Davis, M.D. Medical Examiner.
Date signed 2/9/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25720

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 120a

Registration No. G25720

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hospital
(c) Hospital or institution: W. Fayette Street, Balto. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 Burke Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Bessie Minnick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~or wife~~ Millard A. Minnick
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) April 10, 1915

8. AGE: Years	Months	Days	If less than one day
29	10	—	— hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Frederick Laug
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Millard A. Minnick
(b) Address 200 Burke Ave., Towson, Md.

17 (a) Burial (b) Date thereof Feb. 12, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sherwood Cemetery
Location Rockeysville, Balto. Co., Md.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.

19 (a) 2 11 1945 (b)
(Date rec'd by registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10 1945, at 2 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1945, to 2/10 1945, and that I last saw her alive on 2/10 1945.

Immediate cause of death	Duration
Diffuse Peritonitis	2/4/45
Due to Perforation of Ileum.	2/3/45
Due to Regional Ileitis	—
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2/3/45
Major findings of operation: Regional Ileitis
of autopsy: Same.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Symmers Royer M. D.
Address Bon Secours Hosp., Date signed 2/10/45

G25721

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G25721 — 937 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2614 Llewyln Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2614 Llewyln Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ferdinand Mihm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Elizabeth Mihm

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 20 1865

8. AGE: Years 79 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Casper Mihm
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Ferdinand A. Mihm
(b) Address 2626 Llewelyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John C. Miller Inc.
(b) Address 2435 E. Oliver St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 101

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1940, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h/s death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Thrombosis

Due to Arteriosclerotic C.V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner.

Date signed 2/9/40

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G25722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G25722

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1751 Clarkson
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1751 Clarkson
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Greb

3 (b) If veteran, name war: 1st World War
3 (c) Social Security Account No. 705-06-3467
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Bertha Greb
6 (c) If alive, give age 57 years
7. Birth date of deceased (mo., day, yr.) Nov 10, 1887
8. AGE: Years 57 | Months 2 | Days 25 | If less than one day: hr. min.
9. Birthplace Balto, Md (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business B&O R.R.

FATHER
12. Name Carl Greb
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Krummelbein
15. Birthplace Germany

16 (a) Informant Bertha Greb
(b) Address 1751 Clarkson St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 13 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore Md
18 (a) Funeral director A. Bowyer Evans
(b) Address 1420 Edmondson Ave
19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

FEB 11 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8, 1945 at 2 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from 1/22/ 1945 to 2/8/ 1945 and that I last saw him alive on 2/7/ 1945.

Immediate cause of death	Duration
Coronary Thrombosis	17 days
Due to	
Due to	
Other Conditions Hypertensive cardio vascular disease (Include pregnancy within 3 months of death)	?

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Deiel M. D.
Address 1226 Hanover St. Date signed 2/9/45

X

G25723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G25723 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1508 Marshall St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days) 66

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 Marshall
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George M. McNamee

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Anna E. McNamee
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Nov. 6 1874

8. AGE: Years 70 | Months 3 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Johnstown Pa
(City, county, and state)
10. Usual Occupation Balt. C. Dept
11. Industry or business

FATHER
12. Name Michael McNamee
13. Birthplace Ireland

MOTHER
14. Maiden Name Anna Gallagher
15. Birthplace Ireland

16 (a) Informant Anna E McNamee
(b) Address Husband 1508 Marshall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12, 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto City

18 (a) Funeral director A. Russell Evans
(b) Address 1400 Eutaw St

19 (a) Date received by registrar Feb 11 1945 (b) Registrar Harrington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 1945, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1945 to Feb 9 1945, and that I last saw h[illegible] alive on Feb 9 1945.

Immediate cause of death: Cardiac Failure — Duration: 2 hrs
Due to: Senile Myocarditis — 2 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature H. L. Faulkner M.D.
Address 1508 Marshall St Date signed Feb 10 1945

G25724

HEALTH DEPARTMENT—CITY OF BALTIMORE

G25724

CERTIFICATE OF DEATH

1937

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3951 Falls Road St. 7 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME Margaret Hanratty

If U. S. Veteran specify WAR

(a) Residence: No. 3951 Falls Rd St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of John Hanratty

6. DATE OF BIRTH (month, day, year) Mar. 1867

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
76	11		

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Ireland

FATHER

13. NAME John Hagan

14. BIRTHPLACE (city or town) (State or country) Ireland

MOTHER

15. MAIDEN NAME Mary ?

16. BIRTHPLACE (city or town) (State or country) Ireland

17. INFORMANT Miss Bessie Hanratty

(Address) 3951 Falls Road

18. BURIAL, CREMATION, OR REMOVAL

Place Holy Redeemer, Feb. 12, 1937

19. UNDERTAKER Rita Wiedefeld

(Address) 914 Greenmount Ave

20. FILED FEB 11 1937 Huntington Williams, M.D. Registrar.

Stinnanete

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb 10, 1937

22. I HEREBY CERTIFY, That I attended deceased from Feb 5, 1937 to Feb 10, 1937

I last saw her alive on Feb 9, 1937 Death is said to have occurred on the date stated above, at 4 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
~~Hopeless~~ CVD	
Cerebral Hemorhage	Feb 5/37
Other contributory causes of importance:	
Hypertension CVD.	?

Was an operation performed? ... Date of ...

For what disease or injury? ...

Name of operation ...

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?

If so, specify ...

(Signed) Laurence J Slominski M. D.

(Address) 3711 Falls Rd

3711 Falls Rd Stinnanete

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V8 2

G25725 G25725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ +61

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., (mos.), or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Putty Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Dieter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-4-1896

8. AGE: Years	Months	Days	If less than one day
79	-	5	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Glenn L. Martin (Laborer)
11. Industry or business

FATHER 12. Name John W. Dieter
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Mary E. Streb
15. Birthplace Germany

16 (a) Informant Mrs Margaret E. Meaton
(b) Address 4403 Ashburg Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2-12-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md
18 (a) Funeral director J. J. Rusby
(b) Address 5305 Harford Rd
FEB 11 1945 (Date rec'd by registrar) Huntington Williams Mgr.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-9 — 1945 at 1.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24-1944 to 2-9-1945 and that I last saw h im alive on 2-9-1945

Immediate cause of death: Cachexia — Duration 1 Days

Due to Glandular Atrophy (Thyroid, pituitary)

Due to Pyelonephritis (acute)

Other Conditions Diabetes Mellitus (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Severe Pyelonephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allen C. Wooden M. D.
Address W. B. G. H. Date signed 2-9-45

VS 150

133a

G25726 X ✓ G25726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette and John Sts.
(c) Hospital or institution:
Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 64 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Virginia Wolfe

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Married

6 (b) Name of husband or wife Mr. William C. Wolfe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 20, 1874

8. AGE: Years	Months	Days	If less than one day
70	5	22	hr. min.

9. Birthplace Pleasant Valley, Maryland
(Town, county, and state)

10. Usual Occupation Home maker

11. Industry or business

FATHER
12. Name John F. Hesson
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Elizabeth Crawford
15. Birthplace Carroll Co. Md

16 (a) Informant Mr. Wm. E. Wolfe
(b) Address 64 Penn. Ave. Westminster Md

17 (a) Burial (b) Date thereof 2 14 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery Medas Branch
Location Near Westminster, Md.

18 (a) Funeral director J. E. Myers, Jr.
(b) Address Westminster, Md.

19 FEB 12 1945 (b) Huntington, Williams, Md.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11, 1945, at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from January 24, 1945, to February 11, 1945, and that I last saw her alive on February 11, 1945.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Arteriosclerotic Cardio-Vascular Disease	
Due to with hypertension in left axilla fracture	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. E. Lamed III M. D.
Address Women's Hospital Date signed 2-11-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

25727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1602

Registered No. 25727

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene Sts
(c) Hospital or institution: University Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3353 Beech Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Clark-B

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1945

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert E Clark.
13. Birthplace Pa

MOTHER
14. Maiden Name Freda M Lindsay
15. Birthplace Md.

16 (a) Informant Peter Lindsay.
(b) Address 3353 Beech Ave

17 (a) Burial (b) Date thereof Feb 12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore

18 (a) Funeral director Chenoweth & Donavan
(b) Address 3616 Chestnut Ave.

19 (a) Date received by registrar FEB 12 1945 (b) Huntington Hillcrest Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9 1945, to 2/10 1945, and that I last saw h.t.m. alive on 2/10 1945

Immediate cause of death Respiratory failure — Duration

Due to Premature intereranial hemorrhage — 1½ day

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation ~~Dec~~ 2/9/45

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles O. Chaput M. D.
Address Redwood + Greene Sts Date signed 2/10/45

X

G25728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No. G25728

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: Univ Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give county)
(d) Street No. 1406 S. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Ellen Smith
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Wm Ed Smith
6 (c) If alive, give age 57 years
7. Birth date of deceased (mo., day, yr.) Nov. 24 1885
8. AGE: Years 59 | Months 2 | Days 14 | If less than one day ..... hr. ..... min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward Fisher
13. Birthplace Md

MOTHER
14. Maiden Name Anna Jane Van Sant
15. Birthplace Md

16 (a) Informant Mr Wm E. Smith
(b) Address 1406 S. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md

18 (a) Funeral director Harry H. Wiltze
(b) Address 1101 Edmondson Ave.

19 (a) FEB 12 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8 1945, at 12 noon

21. I certify that death occurred on the date above stated; that I attended deceased from 2-6 1945 to 2-8 1945 and that I last saw h alive on 2-8 1945.

Immediate cause of death	Duration
Sub Arach Hemorrhage	
Due to Cerebral Vasc Accident	
Due to Arterial Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature R. Huntington Williams M.D.
Address Univ Hosp Date signed 2-9-45

(over)

VS 180

G25729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 15

G25729 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 N. CHARLES ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MR. CLYDE SWACKHAMER

3 (b) If veteran, name war: W

3 (c) Social Security Account No. 217-16-7684

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/17/07

8. AGE: Years	Months	Days	If less than one day
37	6	23	hr. min.

9. Birthplace PENNA. (Town, county, and state)
10. Usual Occupation FIRST AID WORK
11. Industry or business CROWN-CORK & SEAL

FATHER
12. Name Yost Swackhamer
13. Birthplace Pa

MOTHER
14. Maiden Name Lena Van Ness
15. Birthplace Pa

16 (a) Informant Mrs Gould Simonings
(b) Address 108 E. 91st N. Y. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 17 St. Paul St.

FEB 12 1945

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10 1945, at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24 1945 to 2/10 1945; and that I last saw h[illegible]M alive on 2/10 1945.

Immediate cause of death PERITONITIS — Duration

Due to PERFORATION OF ILEUM

Due to TUBERCULOSIS

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/7/45 1/24/45

Major findings of operation: PERFORATION OF ILEUM

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry J. Houska M. D.
Address 1 E. Joseph St Hosp. Date signed 2/10/45

VS 150

G25730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G25730

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Lunacy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Redwood St. - Rooms
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) **FULL NAME** John A. Litz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) About 1883

8. AGE: Years	Months	Days	If less than one day
62 61			.....hr. .....min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Litz
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Katir
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Wm Litz
(b) Address 303 Washburn Ave

17 (a) Burial (b) Date thereof 2/13/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) FEB 12 1945 (Date rec'd by registrar) (b) Huntington Hollingsworth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-9-1945, at 8 50 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 2-9-45

VS 151

Cause of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Especially important.

625731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 Registered No. 625731

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 N. Montford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter O. Taylor

3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-07-6339

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Lydia Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 4th 1873

8. AGE: Years	Months	Days	If less than one day
72	0	4	hr. min.

9. Birthplace Annapolis Md.
(Town, county, and state)
10. Usual Occupation Elevator Operator
11. Industry or business National Can Co.

FATHER
12. Name Geo. T. Taylor
13. Birthplace Annapolis Md

MOTHER
14. Maiden Name Laura V. Micker
15. Birthplace Annapolis Md

16 (a) Informant Mrs Clara Liberty
(b) Address 508 N. Montford Ave

17 (a) Burial (b) Date thereof 2/13/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

FEB 12 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1945, at 7:08 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19.
and that I last saw h/~~e~~r alive on 2/6 19

Immediate cause of death	Duration
Cardio-Resp. Failure	
Due to Cholemia	
Due to Ca. of Head of Pancreas	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1/19
Major findings of operation Cholecystogastrostomy
Biopsy of Liver
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Charles H. Lehman M.D.
Address Sinai Hospital Date signed 2/9/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-50732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1634

Registered No. G-50732

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4233 Euclid Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Rose M. Heinritz

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Robert C. Heinritz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2nd 1903

8. AGE: Years	Months	Days	If less than one day
41	9	8	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant E. Deane Harrington
(b) Address 17 Guilford Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/13/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul

19 (a) FEB 12 1945 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 1945, at 8:35 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Decomposition

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-10- at a. M.
(b) Where did injury occur? 4233 Euclid Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Unknown – kitchen gas range.

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed February 10, 1945

G25733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G25733

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution:
St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Independence St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Sadie Fristsch

3 (b) If veteran, name war W

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph John Fristch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18th 1892

8. AGE: Years 52 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business At Home

FATHER
12. Name Samuel Houston
13. Birthplace Balto Md

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Joseph T. Fristsch
(b) Address 3201 Independence St

17 (a) Burial (b) Date thereof 2/13/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Jac
(b) Address 1317 St Paul St

19 (Date rec'd by reg'r) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-9 1945, at 945 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-8 1945, to 2-9 1945, and that I last saw her alive on 2-9 1945.

Immediate cause of death	Duration
Cerebral Hemorrage	
Due to Severe Hypertension	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M.E. Robertson M. D.
Address St. Josephs Hospital Date signed 2-9-45

VS 150

530

FOR WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

25734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94

Registered No. 625734

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 909 Cathedral St
(c) Hospital or institution: DBA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 909 Cathedral St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Cummings

3 (b) If veteran, name war W

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married.

6 (b) Name of ~~husband or~~ wife Clara Cummings

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 27th 1885

8. AGE: Years 59 | Months 2 | Days 13 | If less than one day hr. min.

9. Birthplace Meadville Pa.
(Town, county, and state)

10. Usual Occupation Expert

11. Industry or business Ammunition

FATHER
12. Name Frank Cummings
13. Birthplace Meadville Pa.

MOTHER
14. Maiden Name Elsie (Unknown)
15. Birthplace "

16 (a) Informant Clara Cummings
(b) Address New Castle Del

17 (a) Burial (b) Date thereof 2/14/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1317 St. Paul St

19 (a) FEB 12 1945 (b) Handling for Williams
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10 1945 at 3:34 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Fubrinsky M.D.
Medical Examiner.
Date signed 2/10/45

Please see that information above is carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 625735

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 Leadenhall
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Leadenhall (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1874

8. AGE: Years	Months	Days	If less than one day
70	9	12	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Thomas Dean
13. Birthplace Va

MOTHER
14. Maiden Name Harriett Bunsdon
15. Birthplace Va

16 (a) Informant Virginus Jones (S)
(b) Address 1203 N. 29. st Richmond Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/45 (month) (day) (year)
(c) Cemetery or crematory Richmond
Location Virginia

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 109 W Montgomery St

19 (a) FEB 12 1945 (Date rec'd by Registrar) (b) Huntington Williamsburg, Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9/ 1945, at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1945 to 2/9 1945 and that I last saw h alive on 2/8 1945

Immediate cause of death 1 Uremia Intestinal Nephritis — Duration: Hours

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Jolliffe M.D.

Address 2329 Jones St Date signed Feb 12 1945

625736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 625736

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1315 Stockton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 n Stockton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph Williams

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	colored	married

6 (b) Name of husband or wife Fannie William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1896

8. AGE: Years	Months	Days	If less than one day
48	9	23	hr. min.

9. Birthplace md (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Fannie William
(b) Address 1315 n. Stockton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director George G. Kelson
(b) Address 1303 Pressiman St

19 FEB 12 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1945 at 3:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5 1945 to 2/10 1945, and that I last saw h alive on Feb 9- 1945.

Immediate cause of death Lobar Pneumonia — Duration 1 hr

Due to — Duration 2 hrs

Due to — Duration —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature B. J. Hatcher
Address 1 W Pa Ave Date signed 2/10/45

X

M. D. B. 1208-0

G25737 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G25737

CERTIFICATE OF DEATH 92D

1. PLACE OF DEATH

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1834 Presstman St., ... Ward)

Length of residence in city or town where death occurred 15 yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Amy Mahoney 15

(a) Residence: No. 1834 Presstman St. 15th Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Arthur Mahoney

6. DATE OF BIRTH (month, day, year) June 15, 1893

7. AGE Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
51	7	24	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 9

11. Total time (years) spent in this occupation Yrs 25yrs

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER

13. NAME Charles Chase

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT Hilda Owens
(Address) 1834 Presstman St

18. BURIAL, CREMATION, OR REMOVAL
Place St Peters cem. Date Feb 13 1945

19. UNDERTAKER George H. Kelson
(Address) 1303 Presstman St

FILED FEB 12 1945 Huntington Williams, M.D.
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) February 9, 1945

22. I HEREBY CERTIFY, That I attended deceased from August 15, 1943 to February 9, 1945

I last saw her alive on February 9, 1945. Death is said to have occurred on the date stated above, at 5:30 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Valvular disease of heart	?

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? Physical Signs & Symptoms Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?
No If so, specify .....

(Signed) John E. L. Camper M. D.

(Address) 639 N. Carey St. Balto. Md

BE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G65738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

P 3a

Registered No. G65738

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2237 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Goodman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-2-92

8. AGE: Years	Months	Days	If less than one day
52	2	9	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Harry Hahn
13. Birthplace Russia

MOTHER
14. Maiden Name Biera Hahn
15. Birthplace Russia

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnel St

18 (a) Funeral director Jas E. Lewis Inc
(b) Address 1439 E. Balt St

PB 1 2 1945 (Date received by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1945 at 5 50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1945 to Feb. 11 1945 and that I last saw h[illegible] alive on Feb. 11 1945

Immediate cause of death Respiratory Failure — Duration

Due to Intracranial hemorrhage — 1 day

Due to Undiagnosed disease with anemia, thrombocytemia + leucopenia — ?

Other Conditions (Rule aplastic anemia)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Cemeron
Address Johns Hopkins Hospital Date signed 2-11-45

VS 150

625739

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 625739

CERTIFICATE OF DEATH 1640 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Bowling Green (If outside city or town limits write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Ralph Wright

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1906

8. AGE: Years	Months	Days	If less than one day
38	3	20	hr. min.

9. Birthplace Eckhart Mines Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name David W. Wright
13. Birthplace Lonaconing Md.

MOTHER
14. Maiden Name Shirley
15. Birthplace Lavale Md.

16 (a) Informant Family Records.
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-14-45 (month) (day) (year)
(c) Cemetery or crematory Eckhart Cem. Location

18 (a) Funeral dir. John O. Mitchell & Son
(b) Address 1900 Eutaw Place

19 (a) FEB 12 1945 (Date rec'd by registrar) Timothy J. Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1945, at 10:25 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
Due to Hanging.
Other Conditions Mental case
(Include pregnancy within 3 months of death)

22. If an external cause was primary ✓ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 11, 1945 M.
(b) Where did injury occur? 706 S. Regester St.
(c) Did injury occur at home, on farm, industrial place, in public place? Vacant house While at work? No
(d) Means of injury Hanging from bannisters
23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed 2-12-45

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Please write the causes of death clearly and legibly. Physicians: please write as especially important. Please write

G25740 ✓ G25740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 N. Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Mrs. Margery Briscoe) Marjorie Norris Briscoe

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. 9[illegible]

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Joseph W Briscoe | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 10 1873

8. AGE: Years 71 | Months 9 | Days 0 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Wm B. Norris

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Adeline Rice Norris

15. Birthplace Pa.

16 (a) Informant Harriet C. Norris

(b) Address 2206 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby. 13/45 (month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Green Mount Ave & Oliver St

18 (a) Funeral director John Quitslund Sons

(b) Address 19 E Eutaw Place

FEB 12 1945 (b) Burlington Williams Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-9 1945, to 2-10 1945, and that I last saw her alive on 2-10 1945

Immediate cause of death	Duration
Respiration	
Due to Internal hernia between omentum and adhesions	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2-10-45

Major findings of operation: Internal hernia between omentum and adhesions

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas P. Elias M. D.

Address Univ. Hosp. Date signed 2-11-45

X

625741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1560 Registered No. 625741

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 St Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max E. Schayer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-22-12

8. AGE: Years 32 | Months 1 | Days 18 | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name Max E. Schayer
13. Birthplace Cal.

MOTHER
14. Maiden Name Mary Stark
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Feb 12 (month) (day) 1945

(c) Cemetery or crematory Loudon Park
Location 3501 Frederick ave

18 (a) Funeral director John J. Williams & Sons
(b) Address 1900 Eutaw Place

19 FEB 12 1945 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1945, at 6 15/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1945 to Feb 10 1945 and that I last saw h[illegible] alive on Feb 10 1945.

Immediate cause of death Peri - Operative Duration
Pneumonitis staphylococcal
Due to Meningitis

Due to

Other Conditions

(Include pregnancy within three months of death)

Date of operation 2/9/45

Major findings of operation: Ruptured Duodenal ulcer, peritonitis.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul W. Chambers
Address Johns Hopkins Hospital signed 2/10/45

VS 150

625742

BENNO WILLIAM SEBALD

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 625742

1. PLACE OF DEATH:
(a) Baltimore City, Maryland SCHOOL #64 GARRISON Y
(b) Street address 3904 Maine Ave. C.H.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 39 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3904 Maine Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Benno W. Sebald

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-01-6942

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Warren Dell Sebald

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 30-1873

8. AGE: Years 71 | Months 5 | Days 8 | If less than one day hr. min.

9. Birthplace Iowa
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Draft Board #23

FATHER
12. Name William Sebald
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Warren D. Sebald
(b) Address 3904 Maine Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12-1945 (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road Waiting for Williams, M.D.

19 (a) FEB 12 1945 Registrar
(Date received)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8 1945 at 9:45 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions Arteriosclerotic C.V. Disease?
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. H. Schmidt M.D.
Medical Examiner.
Date signed 2/8/45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No. G25743

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 830 Hellington Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 830 Hellington Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Howard Alban

3 (b) If veteran, name war —
3 (c) Social Security Account No. 716-12-3486

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Alice L. ~~Little~~ Alban
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 3-1869
8. AGE: Years 75 Months 4 Days 6 If less than one day hr. min.
9. Birthplace Baltimore Co. Maryland (Town, county, and state)
10. Usual Occupation Conductor Pa. R.R.
11. Industry or business Retired 7 years

FATHER
12. Name John Alban
13. Birthplace Baltimore Co. Md.

MOTHER
14. Maiden Name Ann Marie Kinney
15. Birthplace Baltimore Co. Md.

16 (a) Informant Mrs. Alice L. ~~Little~~ Alban
(b) Address 830 Hellington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 13-1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 2945 Frolls Road

19 (a) FEB 13 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9. 1945, at 11.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945, to Feb 9 1945; that I last saw him alive on Feb 9 1945.

	Duration
Immediate cause of death Cerebral Vascular accident (Hemorrhage)	
Due to	
Due to arteriosclerosis	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Wallenstein M. D.
Address 858 W 36 Date signed 2/9/45

VS 150

G25744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 27c

Registered No. G25744

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2224 Orleans Street
(c) Hospital or institution: b-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2224 Orleans Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME NORMAN FRANCIS BARCZAK

3 (b) If veteran, name war ----
3 (c) Social Security Account No. -----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	---

6 (b) Name of husband or wife -----
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 18, 1944

8. AGE: Years	Months	Days	If less than one day
	3	22	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation ---
11. Industry or business

FATHER
12. Name Frank Barczak
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Norma Bohanar
15. Birthplace St. Inigoes, Maryland

16 (a) Informant Mrs. Norma Barczak
(b) Address 2224 Orleans Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski & Son
(b) Address 1808 Eastern Ave.

19 (a) Date received FEB 12 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10/45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1944, to Feb. 10 1945, and that I last saw h-- alive on Feb. 9 1945.

	Duration
Immediate cause of death Myocardial Insufficiency	1 day
Due to Dysentery and Diarrhea	5 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John V. Sadowski, M.D. 31
Address 1802 Eastern Ave Date signed 2-11-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G25745

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Linden Ave.
(c) Hospital or institution:
Maryland General Hospital 15 E 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 4yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 Dukeland St. #16
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edward Kirwan

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Maggie C. KIRWAN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13, 1868

8. AGE: Years 76 | Months 6 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Chester Md.
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name James Edward Kirwin
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary R. Gardner
15. Birthplace Chester Md.

16 (a) Informant hospital records
(b) Address

17 (a) Burial (b) Date thereof 2/13/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Stevensville
Location Stevensville Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) Huntington Williams, M.D.
(Date received by registrar) Registrar

FEB 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10 19 45, at 3 ~~PM~~ AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 19 45, to 2/10 19 45, and that I last saw h alive on 2/10 19 45.

Immediate cause of death: Cerebral Hemorrhage — Duration: 6 hrs.

Due to: Hypertensive C.V. Disease

Due to:

Other Conditions: Arteriosclerosis, Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Genl. Hospital Date signed 2/10/45

93D

G25746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G25746

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2507 Maryland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2507 Maryland Ave.
(If rural, give location)
(e) Citizen of foreign country? (~~Yes~~ or No)
If yes, name country

3 (a) FULL NAME Roberta T. Goldsborough Glover

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband or wife John H Glover
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1878

8. AGE: Years	Months	Days	If less than one day
66	2	23	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Home - mfr
11. Industry or business

FATHER
12. Name John Goldsborough
13. Birthplace Delaware

MOTHER
14. Maiden Name Caroline Tapman
15. Birthplace Baltimore - Md.

16 (a) Informant Mrs. Bertha T. Shamer
(b) Address 3300 W. North Ave.

17 (a) Burial (b) Date thereof 2/13/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 12 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1945 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1945 to Feb. 10 1945, and that I last saw her alive on Feb. 10 1945

	Duration
Immediate cause of death Acute myocarditis	1 mo.
Due to Chronic nephritis	10 yrs.
Due to Cirrhosis of Liver	3 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bertha Tapman Shamer M. D.
Address 3300 West North ave. Date signed 2/11/45

625747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 625747

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4936 Edgemere Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4936 Edgemere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Sterling

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John W. Sterling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ABout 1874

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Crisfield (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Daughterty
13. Birthplace Crisfield

MOTHER
14. Maiden Name Mary Bradshaw
15. Birthplace ?

16 (a) Informant Mr. Crafton Wilson
(b) Address 4936 Edgemere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 13, 1945 (month) (day) (year)
(c) Cemetery or crematory Asbury Cemetery
Location Crisfield, Md.

18 (a) Funeral director John A. Bradshaw
(b) Address Crisfield, Md.

19 FEB 12 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 1945, at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1944 to Feb 9 1945 and that I last saw h[illegible] alive on Feb 8 1945

Immediate cause of death	Duration
Arterio-sclerotic myocarditis & failure	several years
Due to	
Due to	
Other Conditions Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Bradshaw M. D.
Address 5106 Park Heights Ave Date signed 2/10/45

VS 150

5748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 ✓ G25748 Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2233 Division St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2233 Division St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mellie Doman

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-09-8260

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife George Doman

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Mar 31. 1893

8. AGE: Years 51 | Months 11 10 | Days 9 8 | If less than one day hr. min.

9. Birthplace Raleigh N. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At home

FATHER 12. Name Charles Harris

13. Birthplace N. C.

MOTHER 14. Maiden Name Catherine Hatcha

15. Birthplace N. C.

16 (a) Informant George Doman

(b) Address 2233 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Brooklyn Via Brooks

18 (a) Funeral director

(b) Address 1463 N. Carey St

FEB 12 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 1945, at 6.07 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Feb 9 1945 and that I last saw h[illegible] alive on Feb 8 1945

Immediate cause of death Carcinoma of Breast with Metastases — Duration 1942

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Apr. 1942

Major findings of operation: Carcinoma of Breast

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mellie Doman, M.D.

Address 1663 W. North Ave Date signed 2/10/45

5749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45 F Registered No. 5749

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2830 Westtwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2830 Westwood Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Wesley Neal

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife ----

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1880

8. AGE:	Years	Months	Days	If less than one day
	64	10	22	hr. min.

9. Birthplace Alberton, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John W. Neal
13. Birthplace Martinsburg, W. Va.

MOTHER
14. Maiden Name Emily J. Elsroad
15. Birthplace Md.

16 (a) Informant Miss Ella Neal
(b) Address Alberton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12, 1945 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Howard Co., Md.

18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave.,

FEB 12 1945 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1945, at 3.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Feb 9 1945, and that I last saw h~~im~~ alive on Feb 8 1945

Immediate cause of death Carcinoma Jthroat — Duration about 4 yr

Due to

Due to

Other Conditions Carcinoma of throat — about 1944

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter S. Tibbitt M. D.
Address 2220 Garrison Blvd Date signed

Waiting for Williams, M.E.

X Oct 10/46

625750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 625750

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sheep Spring Ave. & Belvedere
(c) Hospital or institution:
LEVINDALE
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Sheep Spring Ave. & Belvedere (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HILDA FOX (BERMAN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Meyer –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Aaron –
13. Birthplace Russia

MOTHER
14. Maiden Name Rifka –
15. Birthplace Russia

16 (a) Informant Wolf Rubin
(b) Address 2624 Parkwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-45 (month) (day) (year)
(c) Cemetery or crematory Linden Mill Rd.
Location

18 (a) Funeral director Jack Levin Bro
(b) Address 1439 E. Balto. St. Huntington Williams, Md.

FEB 12 1945 (Date filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1945, at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24 1944, to 2-11 1945, and that I last saw h[illegible] alive on 2-11 1945.

Immediate cause of death Arteriosclerotic heart disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Levin
Address Levindale Date signed 2/11/45

X

G25751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G25751

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Bon Secours Hospital
(b) Street address 20 25 W. Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6343 Frederick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr William Stein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/4/67

8. AGE: Years 77 | Months 6 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Cigar Business

FATHER 12. Name Wm L Stein

13. Birthplace Maryland

MOTHER 14. Maiden Name Catherine Shuart

15. Birthplace Germany

16 (a) Informant Mrs Edna Stein

(b) Address 6343 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Back entry

18 (a) Funeral director Thos D McCabe

(b) Address 1000 Fremont Ave

19 FEB 12 1945 (Date rec'd by registrar) Huntington Hollins (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10 1945, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/29 1945, to 2/10 1945, and that I last saw him alive on 2/10 1945.

Immediate cause of death	Duration
Acute Congestive Failure	2 days
Due to Coronary Thrombosis	
Due to	
Other Conditions Senile arteriosclerosis (Include pregnancy within 3 months of death)	

Date of operation 1/29/45

Major findings of operation: Acute appendicitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. F. T. Heibel M. D.

Address Bon Secours Hosp. Date signed 2/10/45

VS 150

5752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45 C

G25752 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1073 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 15 1891

8. AGE: Years	Months	Days	If less than one day
53	6	24	hr. min.

9. Birthplace Howard Co., Md.
(Town, county, and state)

10. Usual Occupation Chambermaid

11. Industry or business Balto. Clay-Potter

FATHER
12. Name Tom. Hall
13. Birthplace Westmin, A.A.Co. Md.

MOTHER
14. Maiden Name Alice Plummer
15. Birthplace Howard Co., Md.

16 (a) Informant Lillie Hall Johnson
(b) Address 337 N. Calhoun St.

17 (a) Burial (b) Date thereof Feb 15, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mount Auburn
Location Baltimore City

18 (a) Funeral director Joseph A. Lively
(b) Address 409 N. Mount Street

FEB 12 1945
(Date rec'd by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1945, at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease
Due to
Other Conditions Hypertrophy + dilatation of heart. Edema. Congestion of lungs.
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Cleveden M.D.
Medical Examiner.
Date signed February 10, 1945

correct age is especially important. Physicians: please write the c

625753 Winder

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 93D

625753 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5
(c) Hospital or institution: South Baltimore Gen'l Hosp. 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 S. Catalina St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Winder

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Otho Winder
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Oct 7th 1866

8. AGE: Years	Months	Days	If less than one day
78	4	13	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER 12. Name John Warflein
13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Steenderson
15. Birthplace Germany

16 (a) Informant Katherine Woosley
(b) Address 405 Pitman Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/45 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem. Location East End of North Ave

18 (a) Funeral director John F. Denny Inc
(b) Address 715 Eight St.

19 (a) FEB 12 1945 (Date rec'd by registrar) (b) Thurlington for Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8/45 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/8/45 to 2/8/45 and that I last saw h[illegible] alive on 2/7/45

Immediate cause of death Chronic myocardial degeneration — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T O Passaway M.D.
Address Sp. Balto Gen Hosp Date signed 2/8/45

Typewritten Charles J. LaRocque M.D. per Robert Le Prince M.D.

625754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 C

Registered No. 625754

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1035 Riverside Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1035 Riverside Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph P. Carmine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Married

6 (b) Name of husband or wife Emma L. Carmine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 4, 1881

8. AGE: Years	Months	Days	If less than one day
64	1	6	hr. min.

9. Birthplace Baltimore, Md. (town, county, and state)
10. Usual Occupation Stock Clerk
11. Industry or business

FATHER
12. Name Charles Carmine
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Lamar
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Emma L. Carmine
(b) Address 1035 Riverside Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 13, 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East End of North Ave.

18 (a) Funeral director John F. Denny, Inc.
(b) Address 215 Light St.

19 (a) FEB 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 1945, at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1944 to Feb 10 1945.
and that I last saw h alive on 19

Immediate cause of death	Duration
Carcinoma ?	
Due to Head of Pancreas	4 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: No
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Miller, M.D.
Address 120 S. Charles St. Date signed 2/10/45

VS 150

G25755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G25755 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 738 Reservoir St.
(c) Hospital or institution:
13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 738 Reservoir St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENNIE BLOCK KITCHIN

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife: Frank Gunn Kitchin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 18, 1878

8. AGE: Years	Months	Days	If less than one day
66	9	23	hr. min.

9. Birthplace: Gordonsville, Va.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: William M. Yager
13. Birthplace: Va.

MOTHER
14. Maiden Name: Lillie Carpenter
15. Birthplace: Va.

16 (a) Informant: Mr. William Kitchin
(b) Address: 7 Murray Ave., Annapolis, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/13/45 (month) (day) (year)

(c) Cemetery or crematory
Location: Orange, Va.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) Date received by registrar: FEB 12 1945 (b) Huntington Williams M.D.

VS t80

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11, 1945, at 12:10 am

21. I certify that death occurred on the date above stated; that I attended deceased from July 1940 to Feb 11 1945; and that I last saw h[er] alive on Feb 10 1945.

Immediate cause of death	Duration
Myocarditis	Gradual
Due to Arterio Sclerosis Hypertension	" "
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Moody M.D.
Address 1402 Park Ave Date signed 2/13/45

X

625756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 625756

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4313 Maine Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4313 Maine Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA MICHAEL SHEELY

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm. E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 17, 1873

8. AGE: Years 72 | Months | Days 23 | If less than one day hr. min.

9. Birthplace Hanover Pa.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Althus Michael
13. Birthplace Hanover Pa.

MOTHER
14. Maiden Name Emma Weinbrenner
15. Birthplace Hanover Pa.

16 (a) Informant Mr. Harry M. Sheely
(b) Address 5200 Barribgton Rd.

17 (a) Burial (b) Date thereof 2/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

FEB 12 1945
19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 10 1945 at 8.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to Feb 10 1945, and that I last saw her alive on Feb 10 1945

Immediate cause of death: Coronary artery thrombosis — Duration 2 hrs

Due to: Arteriosclerotic Cardiovascular Disease — Duration 6 yrs

Due to: Chronic myocarditis — Duration 6 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos J. Abbott M. D.
Address 4508 Liberty Heights Ave Date signed 2-12-45

625757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No. 625757

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 911 N. Appleton Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 da
(e) Length of stay in Baltimore (yrs., mos., or days) 81yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James J Kane

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1870

8. AGE: Years	Months	Days	If less than one day
74	8	14	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Retired Family
11. Industry or business

FATHER
12. Name Michael Kane
13. Birthplace Ireland

MOTHER
14. Maiden Name Johanna Griffin
15. Birthplace

16 (a) Informant Mr. Albert M. Kane
(b) Address 911 N. Appleton ST,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/ 12/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William J. Tickner & Spns
(b) Address North & Pa. Aves.

19 (a) FEB 12 1945 (Date received by registrar) Huntington Mills Registrar, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/ 9/ 1945, at 10;15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1944, to Feb. 9 1945, and that I last saw h. alive on Feb. 9 1945.

Immediate cause of death	Duration
Carcinoma of stomach	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Homer A. Todd M. D.
Address 735 N Fulton Av Date signed 2/12/45

G25758

G25758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St. Roland Ave

(c) Hospital or institution:

Sinai Hospt.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) Lifer

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3701 Cottage Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Louis Levi

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Dept.

11. Industry or business

FATHER

12. Name —

13. Birthplace Germany

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant Kurt Weykerd

(b) Address 5123 Merrindale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-45 (month) (day) (year)

(c) Cemetery or crematory Rose dale

Location

18 (a) Funeral director Jos Levin & Sons

(b) Address 1399 E. Balti St

19 (a) FEB 12 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/12 1945, at 6:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/18 1945 to 2/12 1945, and that I last saw him alive on 2/12 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Myocardial Insuff.	
Due to Arteriosclerotic Ht. Dis.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Stanley B. Stein M.D.

Address Sinai Hospital Date signed 2/13/45

625759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

737

Registered No. 625759

JO #92044

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs. 20 min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 622 N. Luzerne Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Appel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Separated

6 (b) Name of husband or wife BARBARA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1893 ?

8. AGE: Years	Months	Days	If less than one day
51?	7?	5?	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Bottler
11. Industry or business National Brewery

FATHER
12. Name Charles (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Mueller (d)
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospital, Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/45 (month) (day) (year)
(c) Cemetery or crematory North Cemty
Location

18 (a) Funeral director Charles E Lehmeyer
(b) Address 2601 E Monument St

19 (a) FEB 12 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1945 at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 9, 1945 to Feb. 9, 1945 and that I last saw him alive on Feb. 9, 1945.

	Duration
Immediate cause of death Pneumonia	?
Due to Unknown Cause	
Due to	
Other Conditions Anuria	?

Due to Unknown Cause
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. M. Mueller M.D.
Address Bolt City Md. Date signed 2-11-45

625760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1108

625760

The Every item of information should be carefully and correctly answered. PRINT PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 Hull St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. Richard Mc Hale

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-07-7606

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 17-1906

8. AGE: Years 38 | Months 9 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Michael Mc Hale
13. Birthplace Ireland

MOTHER 14. Maiden Name Ellen Clark
15. Birthplace Ireland

16 (a) Informant Mrs Mary E. Hart
(b) Address 1311 Hull St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-1945 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Flynning
(b) Address 1402 Eight St.

19 (a) (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

FEB 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9/45 1945 at 4.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/26 1945 to 2/9 1945 and that I last saw him alive on 2/9 1945.

Immediate cause of death	Duration
(a) Pneumonia	
Due to (b)	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. E. Wallens M.D.
M. D.

Address 1400 N. Caroline St Date signed 2-12-45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. 625761

625761

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3606 Menlo Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3606 Menlo Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Arenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Lith
(Town, county, and state)

10. Usual Occupation
11. Industry or business House Wife

FATHER
12. Name Louis Blacker
13. Birthplace Lith

MOTHER
14. Maiden Name Lila Shapiro
15. Birthplace Lith

16 (a) Informant Ellis Arenson
(b) Address 3606 Menlo Drive

17 (a) Burial (b) Date thereof Feb, 12, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sharrei Tfiloh Cem
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

(b) [illegible] Washington Williamsport

FEB 12 1945

VS 150

MEDICAL CERTIFICATION 11

20. DATE OF DEATH February 11 1945 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Feb 11 1945.
and that I last saw her alive on Feb 11 1945.

Immediate cause of death	Duration
Melanotic Sarcoma [illegible] of the rectum	7 mnths
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
M. D.
Address 120 Eutaw Pl Date signed Feb 12/45

625762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59 B

Registered No. 625762

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1116 E. 20th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 E 20th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie Meisel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John Meisel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan - 19 - 1863

8. AGE: Years 82 | Months | Days 22 | If less than one day hr. min.

9. Birthplace Washington D C (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Mr. Wilmot

13. Birthplace Baltimore

MOTHER 14. Maiden Name Kate Norton

15. Birthplace Ireland

16 (a) Informant Gertrude Maulsby

(b) Address 1116 E 20th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Geo C Miller Inc

(b) Address 2435 E Oliver St

19 FEB 12 1945 (Date rec'd by registrar) (b) Huntington Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1945 at 3 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 20 1944 to Feb 10 1945; and that I last saw h alive on Feb 9 1945.

	Duration
Immediate cause of death Hypostatic Pneumonia	2 days
Due to Arteriosclerosis	10 yrs
Due to Arthritis	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred L. Zimmerman M. D.

Address 2868 Hayford Rd Date signed 2-10-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G25763 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 7/31/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 7/31/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town East Lansdowne
(If outside city or town limits, write RURAL and give town)
(d) Street No. 138 Wildwood Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH NEWTON MULLEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mildred Mullen (Howell)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1911

8. AGE: Years 33 | Months 2 | Days 26 | If less than one day hr. 15 min.

9. Birthplace Roanoke, Va.
(Town, county, and state)

10. Usual Occupation AB

11. Industry or business Merchant Seaman

FATHER
12. Name John Mullen
13. Birthplace Va.

MOTHER
14. Maiden Name Ann Hale
15. Birthplace Va.

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart — Location Germany Hill Rd.

18 (a) Funeral director Lee Ades
(b) Address 4644 York Rd.

19 (a) (Signature of local registrar) (b) Huntington Williams, M.D.

FEB 12 1945

VS 150

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH February 10, 1945, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31, 1944, to Feb. 10, 1945, and that I last saw h in alive on Feb. 10, 1945.

Immediate cause of death: Subacute bacterial endocarditis involving the aortic valve — Duration: 3/1944

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin F. Jones M. D.

Address Baltimore, Md. Date signed 2/10/45

MS-54557 X

625764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 194X

Registered No. 625764

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 E. 20th St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Josephine Brown

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6 1907

8. AGE: Years	Months	Days	If less than one day
38	1	4	..... hr. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John H. Rothenberger.
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Not Given
15. Birthplace "

16 (a) Informant Wilson Brown
(b) Address 406 E. 20th St.

17 (a) Burial Burial, cremation, or removal (b) Date thereof Feb 14/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross R.C.
Location R.C.

18 (a) Funeral director Geo M. Frutchey Son
(b) Address 611 N Eutaw St

FEB 12 1945 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/4 1945, at 10:20 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Methyl Salicylate (oil of Wintergreen).

Due to Methyl Salicylate

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/9/45 at 12/4 8:30 P.M.
(b) Where did injury occur? 406 E. 20th St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Ingestion of oil of Wintergreen

23. Signature Leonard E. Miller M.D.
Medical Examiner.
Date signed 2/11/45

(OVER)

625765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

625765 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 342 S. Franklintown Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 342 S. Franklintown Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles G. Hittel

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Frances R. Hittel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 14, 1871

8. AGE: Years 73 | Months 4 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Retired

FATHER
12. Name Martin Hittel
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Elizabeth Fuhrmann
(b) Address 342 S. Franklintown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 13, 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director George V. Sapharl
(b) Address 2101 Frederick Ave.

19 FEB 10 1945 (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1945, at 2:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1945, to Feb 10 1945 and that I last saw him alive on Feb 10 1945.

Immediate cause of death: Coronary Occlusion — Duration 1½hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Collins M.D. M. D.
Address 3821 Frederick Ave Date signed 2-11-45

VS 180

65766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. 65766

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1129 Hollins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herbert W. Payton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1912

8. AGE: Years	Months	Days	If less than one day
32	2	23	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George Payton
13. Birthplace Piedmont, W. Va.

MOTHER
14. Maiden Name Ida Fowble
15. Birthplace Maryland

16 (a) Informant Mrs. Ida Payton
(b) Address 1129 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 13/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Co
Location Woodlawn Balto Md

18 (a) Funeral director John J. Cowen & Son
(b) Address 901 03 Harlem Av

FEB 12 1945 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 1945 at 9 A. M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Shock

Due to 2nd & 3rd degree burns

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-10-45 at A. M.
(b) Where did injury occur? 1129 Hollins St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Bedclothes ignited from oil stove

23. Signature Howard J. Mullin M.D. Medical Examiner.
Date signed Feb. 10, 1945

VS 151

correct age is especially important. Physicians: please write the

625767
AB-91955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625767 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 829 McKim St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Annie May Long

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3- 1862

8. AGE: Years 83 | Months 1 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Kansas City
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Upton
13. Birthplace ?

MOTHER
14. Maiden Name Catherine Ahern
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) burial (b) Date thereof 2/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Road

18 (a) Funeral director John F. Cowan & Son
(b) Address 9011 03 Holliday Street

19 (a) 2-9-1945 (b) Huntington Williams, M.D. Registrar
(Date received by Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8- 1945 at 5.15P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3- 1945 to 2-8 1945 and that I last saw h... alive on 2-8- 1945.

Immediate cause of death	Duration
Lobar pneumonia	?
Due to	
Due to	
Other Conditions Renal cyst	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospitals Date signed 9-10-45

25768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 25768

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 216 N Lemmale Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days) Natives

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 N Lemmale Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Henson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Morgan Henson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/14/1866

8. AGE: Years 78 | Months 4 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace St Marys Co Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Joseph Filan

13. Birthplace St Marys Co, Md

MOTHER 14. Maiden Name Winnie

15. Birthplace St Marys Co. Md

16 (a) Informant Mrs Rosie Fields

(b) Address 1216 N Lemmale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12, 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 3221 Schroeder St

FEB 12 1945 (b) Katie R Williams for Williams M.P. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1945, at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Feb 8 1945 and that I last saw h... alive on Feb 8 1945

Immediate cause of death: Cardiac Decompensation

Due to: Insane

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 1 yr 3 c

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H Watts M.D.

Address 1-154 Calvert Bldg Date signed 2/10/45

X

G25769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G25769

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 853 N. Fayette St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Prof Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No. 250-12-1279

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace Fairfield County, S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Press Thompson
13. Birthplace S.C.

MOTHER
14. Maiden Name Elizabeth Johnson
15. Birthplace S.C.

16 (a) Informant Fred Thompson
(b) Address 1054 W. Fayette St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/13/45 (month) (day) (year)

(c) Cemetery or crematory
Location Winnsboro S.C.

18 (a) Funeral director Joseph B. Locke Jr.
(b) Address 1304 N. Central Ave.

1945 (Date filed by registrar) (b)

Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 1945, at 5:25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured 1st 2nd Cervical Vertebrae

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-10-45 at A. M.
(b) Where did injury occur? 853 W. Fayette St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell down steps at home.

23. Signature Howard J. Mullis M.D.
Medical Examiner.
Date signed February 10, 1945

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G25770

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1521 W 36th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 Baldwin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter W. Broyles.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married.

6 (b) Name of husband or wife Rebecca L. Broyles
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) Aug 22, 1851

8. AGE: Years	Months	Days	If less than one day
93	5	18	..... hr. ..... min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Mill Hand.
11. Industry or business Retired

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Rebecca L. Broyles.
(b) Address 1521 W 36th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 13/45 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Schmidt & Donovan
(b) Address 1515-17 Pennsylvania Ave.

FEB 12 1945
(Date rec'd by registrar) (b) Huntington Williamson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 1945; at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1943 to Feb. 10 1945 and that I last saw him alive on Feb 8, 1945.

Immediate cause of death: Coronary occlusion
Coronary thrombosis — Duration

Due to: Coronary sclerosis
Due to: & arteriosclerotic Heart disease

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Wallenstein M. D.
Address 848 W 36th St Date signed 2/12/45

X

G25771

G25771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the entries especially important. Entries must be complete.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Streets
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 West 28th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SOPHIA McCANDLESS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Jesse McCandless

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) July 7, 1875

8. AGE: Years 69 | Months 7 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace South America. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Pearce
13. Birthplace England.

MOTHER
14. Maiden Name Mary Roberts
15. Birthplace Wales.

16 (a) Informant Jesse Mc Candless
(b) Address 400 W 28th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14, 1945 (month) (day) (year)
(c) Cemetery or crematory Slate Ridge.
Location Delta, Pa.

18 (a) Funeral director Ebenezer B. Donovan
(b) Address 3615 17 Chestnut Ave.

19 (a) FEB 12 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11, 1945, at 1:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joshua R. Dawson M.D. Medical Examiner.
Date signed February 11, 1945

X

625772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G25772

171a

Please fill in the blanks with the greatest care. The information supplied will be used to compile the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town (If outside city or town limits, write RURAL and name town)
(d) Street No. Second & Edison Sts (Trailer Camp) (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles R. Mullens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
52 51			hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15-45 (month) (day) (year)
(c) Cemetery or crematory
Location Westernport. Md.

18 (a) Funeral director John A. Hogan
(b) Address Box E. Cabin St.

19 (a) FEB 12 1945 (Date rec'd by Registrar) Huntington Williamsport Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11, 1945, at 4:40 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Juss death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured Skull
Fractured Ribs
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/4
(a) Date of injury 1 04 A.M. 2/8/45
(b) Where did injury occur? Potapsco Ave & Smith Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Howard J. Mullens, M.D. Medical Examiner.
Date signed February 12, 1945.

VS 151

G25773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G25773

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4305 Old York Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4305 Old York Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry A Holman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~.
Male	White	Widow

6 (b) Name of husband or ~~wife~~ Etta Barbara A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28 1859

8. AGE: Years	Months	Days	If less than one day
85	9	22	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name John Holman
13. Birthplace Germany

MOTHER
14. Maiden Name Frances ?
15. Birthplace Germany

16 (a) Informant Henry J. Holman
(b) Address Linville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 13 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19 (a) FEB 12 1945 (Date rec'd by registrar) (b) Clayton Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10th 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1945 to Feb 10 1945, and that I last saw him alive on Feb 9th 1945

Immediate cause of death	Duration
Cardiac Thrombosis	1 day
Due to Senile Myocarditis	3 mos
Due to Arteriosclerosis	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. F. Hare M.D.
Address 8 E 39th St Date signed 2/10/45

VS 150

625774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 625774

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2605 E Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6"
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2605 E Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James T. Smith

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, ~~married~~, widowed, or ~~divorced~~
Male	White	Widow

6 (b) Name of husband or wife Mary E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8 1867

8. AGE: Years	Months	Days	If less than one day
77 78	9	4	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business None

FATHER
12. Name Thomas J Smith
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Couch
15. Birthplace Md

16 (a) Informant Elizabeth Smith
(b) Address 2605 E Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

FEB 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1945 to Feb 12 1945
and that I last saw h[illegible] alive on Feb 11 1945.

Immediate cause of death Cerebral Hemorrhage
Conv.

Due to

Due to Cardio-Renal Dis.
Hypertension

Other Conditions Arterio. Sclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3 days.
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C N Peters M.D.
Address 1501 E 33rd Date signed Feb 13 1945

G25775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G25775
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 32 Nunnery Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Saffron

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mattie Wrightson
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) May 7, 1885

8. AGE: Years	Months	Days	If less than one day
59	9	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Supt. of Bldg.
11. Industry or business Maryland Institute

FATHER
12. Name John C. Saffran
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Werb
15. Birthplace Baltimore

16 (a) Informant Mrs Mattie Saffran
(b) Address 32 Nunnery Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Frederick A. Dole
(b) Address 300 W Lombard St.

19 (a) FEB 12 1945 (Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 1945, at 9:15 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions Acute Congestive Cardiac Failure

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weldon M.D.
Medical Examiner.
Date signed February 10, 1945

Huntington Williams, M.D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G25776 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3311 Lyndale Ave.
(c) Hospital or institution: 8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3311 Lyndale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JULIA CHRISTINE KUHN

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife: - -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12. 1858

8. AGE: Years 86 | Months 4 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Jacob Kuhn
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Adam
15. Birthplace Germany

16 (a) Informant Mrs. W. Kuhn
(b) Address 3311 Lyndale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 13 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address North Ave. & Broadway.

FEB 12 1945 (Date received by registrar) (b) Huntington Willis Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10. 1945 at 1.00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25- 1945 to 2-10- 1945 and that I last saw her alive on 2-7- 1945

Immediate cause of death: Cardio-vascular-renal disease — Duration: 2 yrs

Due to: Generalized arteriosclerosis — Duration: Unknown

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton C. Carey M. D.
Address 2117 Belair Rd Date signed 2-10-45

X

625777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

625777 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1706 Normal Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 3
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs,

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Normal Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA ELIZABETH DEHLER

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: Edward J. Dehler
6 (c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Jan. 13, 1881

8. AGE: Years: 64 | Months: | Days: 25 | If less than one day: hr. 30 min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: James H. West
13. Birthplace: VIRGINIA

MOTHER
14. Maiden Name: Ida M. Jenkins
15. Birthplace: Annapolis Co. Md

16 (a) Informant: Edward J. Dehler
(b) Address: 1706 Normal Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-45 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Avenue & Broadway

19 (a) FEB 12 1945 (Date rec'd by registrar) (b) Registrar: Lucretia Worthington for William

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 11 1945, at 11.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feby 7 1945 to Feby 11 1945, and that I last saw h[illegible] alive on Feby 10 1945.

	Duration
Immediate cause of death: Acute Cardiac Failure	
Due to: Myocarditis	6 months
Due to:	
Other Conditions: Hypertension Nephritis. (Include pregnancy within 3 months of death)	

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J. H. MacMurchy M. D.
Address: 1716 Normal Ave (Physician signing)

93E

625778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625778

Registered No. 937

YA-33642

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs., 8 mos., 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Slayman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mail (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1880

8. AGE: Years 64 | Months 9 | Days 12 13 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Ranael
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Wood
15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 18-45 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cem
Location

18 (a) Funeral director Charles P Fogwell
(b) Address 2427 Monument Ave.

19 (a) FEB 12 1945 (Date received by registrar) (b) Registrar Huntington Williams M.D.

VS t50

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11, 1945, at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-25- 1938, to 2-11- 1945, and that I last saw her alive on 2-11- 1945.

Immediate cause of death: Bronchopneumonia — Duration: 2 wks

Due to:

Due to:

Other Conditions: Hypertension; Chronic Cardiovascular disease Cerebral Thrombosis
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospital Date signed 2-11-45

107

625779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64

625779 Registered No.

Type or print. Information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.D.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 W. Fayette (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Woodrow Elby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
—	3	—	hr. min.

9. Birthplace Florence, S.C. (Town, county, and state)

10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Mike Elby, Jr.
13. Birthplace Lynchburg, S.C.

MOTHER
14. Maiden Name Ethel Harkless.
15. Birthplace Florence, S.C.

16 (a) Informant Mike Elby, Jr.
(b) Address 1010 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. (month) '45 (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans, Md.

18 (a) Funeral director [redacted] R. William
(b) Address 322 N. Schroeder St.

19 (a) FEB 2 1945 (Date rec'd by registrar) (b) [redacted] for Williams M.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11, 1945, at 9 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status Thymicus

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Mercer M.D. Medical Examiner.
Date signed 2-12-45

VS 151

G25780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77D

Registered No. G25780

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 S. Bratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Howard Love

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 12 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 12 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

2503

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30- 1945 at 9:35 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Congestive Cardiac Failure

Due to ASHD

Other Conditions Congestion of lungs, brain, Glaucoma of Left Eye. Exposure to
(Include pregnancy within 3 months of death) Extreme Cold

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 1-30-45

VS 151

OVER

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

G25781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G25781
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2323 Harlem Avenue
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 69 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2323 Harlem Avenue
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Annie Cecelia Reynolds

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Harry A. Reynolds
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) June 15, 1875

8. AGE: Years	Months	Days	If less than one day
69	7	25	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name John J. Duffy, Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary V. O'Brien
15. Birthplace Ireland

16 (a) Informant Miss Alice V. Reynolds
(b) Address 2323 Harlem Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears & Son
(b) Address 805 N. Calvert Street

FEB 12 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1945, at 9:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1943 to Feb 10 1945, and that I last saw her alive on Feb 9 1945

Immediate cause of death	Duration
Coronary Thrombosis	15 Min.
Due to Hypertensive Arterio Sclerotic heart disease	4 yrs?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Mallon M. D.
Address 3321 Fred Ave Date signed 2-12-45

G25782 ✓ G25782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1905 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltiore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin A. Carrick

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1870

8. AGE: Years 80 | Months 8 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace: Prince George Co. Md.
(Town, county, and state)
10. Usual Occupation: Retired Motorman
11. Industry or business: Baltimore Transit Co.

FATHER
12. Name: Amos Carrick
13. Birthplace: Prince George CO. Md.

MOTHER
14. Maiden Name: Susanna King
15. Birthplace: Prince George CO. Md.

16 (a) Informant: Mr. Ralph R. Carrick Sr.
(b) Address: 5217 Wilton Heights

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/45 (month) (day) (year)
(c) Cemetery or crematory: Lorraine
Location: Woodlawn

18 (a) Funeral director: William J. Tickner & Sons
(b) Address: North & Pa. Aves.

FEB 12 1945 Huntington Williams Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH 2/9/1945 at 6 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1943 to Feb. 9 1945 and that I last saw h[illegible] alive on Feb 9 1945

Immediate cause of death: Hypertensive arterio-sclerotic C-V disease

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Granger M.D. (M. D.)
Address 1402 E. Lanvale Date signed 2-12-45

G25783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

G25783 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 811 E. 33rd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 811 E. 33rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEWIS HYDE ADDISON, SR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Nettie Addison
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1882

8. AGE: Years	Months	Days	If less than one day
62	6	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Optometrist
11. Industry or business

FATHER
12. Name George C. Addison
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Gertrude Linthicum
15. Birthplace Howard Co., Md.

16 (a) Informant Mrs. Nettie Addison
(b) Address 811 E. 33rd St.

17 (a) Burial (b) Date thereof 2/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 FEB 13 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11, 1945, at 11:10 am

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1944 to Feb 11 1945.
and that I last saw him alive on Feb 11 1945.

Immediate cause of death Carcinoma of the Liver
Due to Gangrene of toes
Due to Secondary Anaemia

Duration
5 yrs.
3 mos.
2 yrs.

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. S. Lefty M. D.
Address 43 W. Patterson Park Date signed 2/12/45

G25784 ✓ G25784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 931

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5325 Fernpark Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) ✓ City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5325 Fernpark Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE V. L. HUMPHREYS

3 (b) If veteran, name war: --

3 (c) Social Security Account No. 212-09-2786

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1889

8. AGE: Years	Months	Days	If less than one day
55	10	14	hr. min.

9. Birthplace A. A. Co., Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business U. S. F. & G. Co.

FATHER
12. Name Joshua Humphreys
13. Birthplace Md.

MOTHER
14. Maiden Name Sally Dave
15. Birthplace Md.

16 (a) Informant Mrs. Robert G. Humphreys
(b) Address 5324 Fernpark Ave.

17 (a) Burial (b) Date thereof 2/13/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 2 (Date rec'd by registrar) (b) by Hunter Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10, 1945, at 10:00 am

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to 2/10 1945, and that I last saw h[illegible] alive on 2/9 1945.

Immediate cause of death	Duration
Coronary occlusion	one day
Due to	
Due to	
Other Conditions Hypertension Heart Disease	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack. R. Morgan M. D.

Address 5 E. Read St Date signed 2/14/45

X

625785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 625785

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wk
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 Retreat St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine C. Kaufman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband: August Kaufman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2 1905

8. AGE: Years 39 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mary L. Baker
(b) Address 1132 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Wilson Cook Co
(b) Address 214 N Paca St

19 (a) FEB 13 1945 (Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10 1945, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. C. Schleininger M.D.
Medical Examiner.
Date signed 2/10/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

623786 ✓ 623786

YA

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Aveme
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos., 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1658 E. 25th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Benner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 29, 1886

8. AGE: Years 58 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Carson (d)
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Margaret Wolfe (d)
15. Birthplace Pennsylvania

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilson Cook Inc
(b) Address 1217 Park Ave

19 FEB 12 1945 (Date rec'd by registrar) Hunter for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 1945, at 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30, 1944, to Feb. 10, 1945, and that I last saw her alive on Feb. 10, 1945.

	Duration
Immediate cause of death: Pulmonary embolus & infarction	?
Due to: Fractured femoral transmalis	?
Due to:	
Other Conditions: Lobar pneumonia Incurred while asleep (Include pregnancy within 3 months of death)	?

Date of operation
Major findings of operation:
of autopsy: Same.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospitals Date signed 2-11-45

VS 150

99

G25787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. G25787

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 N. Lakewood Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice R. White

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-14-6276

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Fannie E

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) July 24th 1880

8. AGE: Years 64 | Months 6 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER 12. Name William

13. Birthplace Maryland

MOTHER 14. Maiden Name Sarah Holland

15. Birthplace Somerset Co. Md.

16 (a) Informant Nolan E. White

(b) Address 934 Argonne Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/45 (month) (day) (year)

(c) Cemetery or crematory Maryland Park

Location Parkville Md.

18 (a) Funeral director William Cook Inc

(b) Address 1527 St. Paul St

19 (a) (Date rec'd by registrar) FEB 13 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1945 at 4 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1945 to Feb 12 1945, and that I last saw him alive on Feb 12 1945.

Immediate cause of death Resp. Failure — Duration Unknown

Due to Possible multiple myeloma

Due to Possible carcinomatosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Not done

of autopsy: Not done

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Millard T. Trahorn Jr M.D.

Address University Hospital Date signed 2/13/45

VS 150

625788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 H

625788 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (3)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 N. Kenwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia (Lemakis) Fletcher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married, widowed, or~~ divorced: Divorced

6 (b) Name of husband or ~~wife~~: George Lemakis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28th 1901

8. AGE: Years	Months	Days	If less than one day
43	1	13	hr. min.

9. Birthplace: Winchester Va
(Town, county, and state)

10. Usual Occupation: Home wife

11. Industry or business: at Home

FATHER
12. Name: Benjamin Wakely
13. Birthplace: Va.

MOTHER
14. Maiden Name: Martha (Unknown)
15. Birthplace: Va.

16 (a) Informant: Francis Belt
(b) Address: 1027 N. Kenwood Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/15/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Woodland Park
Location: Parkville Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St Paul St.

19 (a) FEB 13 1945 (Date rec'd by registrar) (b) Huntington-Williams, Inc. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1945, at 8:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation

Due to: Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury February 11, 1945 M.
(b) Where did injury occur? 1027 N. Kenwood Ave
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No.
(d) Means of injury Asphyxiation due to illuminating gas

23. Signature: Howard J. Mueller M.D.
Medical Examiner.
Date signed 2-12-45

correct age is especially important. Physicians: please write the

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 6789

5789

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4004 Belvieu Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4004 Belvieu Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace F. Powder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or wife: Chas. A. Powder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18 1853

8. AGE: Years 92 | Months 0 | Days 31 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business None

FATHER
12. Name David Steiner
13. Birthplace Frederick Md.

MOTHER
14. Maiden Name Elizabeth Weis
15. Birthplace Frederick Md.

16 (a) Informant F. S. Cook
(b) Address Equitable Bldg

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/14/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) Date received by Local Registrar FEB 13 1945 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to Feb 11 1945; and that I last saw h[er] alive on Feb 10 1945.

Immediate cause of death	Duration
Cardiac decompensation	2 days
Due to Hypertensive cardio-vascular disease	5 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen F. Kuehnau M. D.

Address 6 E Biddle St Date signed 2/12/45

X

625790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

625790 Registered No.

Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Charles
(c) City or town Marbury
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur G. Goode

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White.	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-6-45

8. AGE: Years	Months	Days	If less than one day
		10	hr. min.

9. Birthplace Md. (town, county, and state)
10. Usual Occupation Child
11. Industry or business —

FATHER 12. Name Arthur G. Goode
13. Birthplace Md.

MOTHER 14. Maiden Name Hazel Riam
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-45 (month) (day) (year)
(c) Cemetery Pikesville Md
Location

18 (a) Funeral director Hunt & Ryan
(b) Address Waldorf Md

FEB 13 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb-12 1945, at 4.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-11 1945, to Feb 12 1945, and that I last saw him alive on Feb-12 1945.

Immediate cause of death: Respiratory failure — Duration 48 hrs

Due to Cerebral Hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert Kaye M. D.
Address JHH Date signed 2/12/45

VS 150

625791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

58B

Registered No. 625791

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 14

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Fredrick (If outside city or town limits, write RURAL and give town)
(d) Street No. 256 S. Carrol St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Gilbert E. Tracey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years 27 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Fredrick Maryland (Town, county, and state)

10. Usual Occupation Press Operator

11. Industry or business Eveready Co.

FATHER
12. Name Frank H. Tracey
13. Birthplace Maryland

MOTHER
14. Maiden Name Marian Oden
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Frederick Md

18 (a) Funeral director M R Eckman & Son
(b) Address Frederick Md

19 (a) FEB 13 1945 (Date received by local registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11, 1945, at 1:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1945, to Feb 11 1945, and that I last saw h[illegible] alive on Feb 11 1945.

Immediate cause of death	Duration
Probable cerebral embolism	
Due to Subacute bacterial Endocarditis	
Due to Rheumatic fever	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Roy Byron Turner Jr. M. D.
Address Mercy Hospital Date signed 2/11/45

VS 150

G25792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

TN. 91855

Registered No. G25792

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2256 Morris St
(If rural give location)
(e) Citizen of foreign country? (Name of country, or No)
If yes, name country

3 (a) FULL NAME Jess Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25th. 1885

8. AGE: Years	Months	Days	If less than one day
59	2	9	hr. min.

9. Birthplace S. C
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jeff Wilson
13. Birthplace S. C

MOTHER
14. Maiden Name Jane ?
15. Birthplace S. C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 12 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) FEB 13 1945 (Date rec'd by registrar) (Signature) Hunterdon Williams M.D.

2507

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4th, 1945 19 at 1.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 29, 45 19 to Feb. 2 19 45 and that I last saw him alive on 19

Immediate cause of death	Duration
Pulmonary Tuberculosis	1
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lee Edmunds M. D.
Address Baltimore, Md Date signed 2-8-45

625793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9 × 625793 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County Baltimore
(c) City or town Sparrows Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bx 675 Rt. 10
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earle Johnson ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-26-44

8. AGE: Years | Months: 6 | Days: 9 | If less than one day: hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Clarence Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Dorothy Edwards
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 12 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 3 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1945 at 10 25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1945 to Feb 5 1945 and that I last saw him alive on Feb 5 1945

Immediate cause of death: Pertussis with bronchopneumonia — Duration: 12 days

Due to — Duration: 10 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert W. Wilkerson M.D.
Address Johns Hopkins Hospital Date signed 2/5/45

VS 150

2505 ×

625734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 625734

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1230 W. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1230 W. North Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME not named Baby Boy Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Infant

6 (b) Name of husband or wife Not Married

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 10 1945

8. AGE: Years	Months	Days	If less than one day
–	–	–	7 hr. 15 min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Charles Watkins
13. Birthplace Elton Va

MOTHER
14. Maiden Name Pinkie Lee Thomquest
15. Birthplace Harmon Va

16 (a) Informant Charles Watkins
(b) Address 1730 W. North Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location FEB 12 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 13 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 10 1945, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1945 to Feb 10 1945 and that I last saw h alive on Feb 10 1945

Immediate cause of death Premature Birth — Duration 6 hours before birth

Due to some febrile condition of Mother

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. W Keown
Address 1938 Linden Ave Date signed 2/10/45

VS 3

2504

X

625735

AB-91328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

114D

Registered No. 625735

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos- 6days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Rural

(If outside city or town limits, write RURAL and give town)

(d) Street No. 8015 Chesaco Ave. or 1221 Chesaco Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Frederick Elgert or Frederick Alger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4- 1878

8. AGE: Years	Months	Days	If less than one day
66	1	30 29	hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name William Elgert or Alger (D)

13. Birthplace Maryland

MOTHER

14. Maiden Name Elizabeth ? (D)

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals (Records)

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL FEB 12 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) FEB 3 1945 Huntington Williams, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3- 1945, at 2.34 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28- 1944 to 2-3- 1945, and that I last saw h im alive on 2-3- 1945

Immediate cause of death Lung Abscess

Duration

Secondary - Carcinoma

Due to

Due to

Other Conditions Generalized arteriosclerosis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Lung Abscess

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature A Butler

Address City Hospitals Date signed 2-11-45

VS 150

2506

625796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61 Y

Registered No. 625796

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Cheyney Court + Dukeland St

(c) Hospital or institution West Balto. Gen. Hosp. 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2522 Keyworth Ave. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Selik Grebow

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Peter Sadie R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4. 1872

8. AGE: Years	Months	Days	If less than one day
72	7	8	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Realestate

11. Industry or business

FATHER 12. Name Aaron Grebow

13. Birthplace Russia

MOTHER 14. Maiden Name Ida —

15. Birthplace Russia

16 (a) Informant Maurice J. Grebow

(b) Address 3321 W. Garrison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 13/45 (month) (day) (year)

(c) Cemetery or crematory Windsor Mill Road

Location

18 (a) Funeral director Sol Levinson + Bros

(b) Address 1714-26 W. North ave

19 (a) FEB 13 1945 (Date rec'd by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/12 1945, at 11:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/11 1945 to 2/12 1945, and that I last saw h alive on 2/12 1945

Immediate cause of death Heart Block 2:1

Cardiac decompensation

Due to Arteriosclerosis C.V.D.

Due to Diabetes Mellitus

Other Conditions Acidosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 1 day

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Irving J. Taylor M.D.

Address WB 6 W Date signed 2/13/45

VS 150

G25797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

G25797 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 716 S. Bethel St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 716 S. Bethel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annette C. Paulson

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles Paulson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11-1882

8. AGE: Years	Months	Days	If less than one day
62	11	30	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Benjamin Harrison
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Cromin
15. Birthplace Baltimore Md.

16 (a) Informant Charles Paulson (Hus)
(b) Address 716 S. Bethel St.

17 (a) Burial (b) Date thereof Feb. 14-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Road

18 (a) Funeral director Lilly and Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 (a) FEB 13 1945 (b) Huntington Williams Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1945, at 8 p.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to Feb 10 1945 and that I last saw h.. alive on Feb. 10 1945

Immediate cause of death Hypertension Cardio Vascular Renal Disease — Duration

Due to

Due to

Other Conditions

(Incinde pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Andrew Simmons M. D.
Address 2529 Eastern Ave. Date signed

X

6-54 Transcripts. ✓ 625798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D.14.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 W. Mens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Russell Webb

3 (b) If veteran, name war

3 (c) Social Security Account No. 212 05 8119

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Madeline W. nee Ault

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20 1900

8. AGE: Years 72 | Months 9 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Supervisor

11. Industry or business Swindell Glass Co.

FATHER
12. Name James Hall Webb
13. Birthplace Va

MOTHER
14. Maiden Name Chloe Pittman
15. Birthplace Va.

16 (a) Informant Mrs. Arthur N. Ault
(b) Address 333 S. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Nitske
(b) Address 416 E Almondson
(c) FEB 13 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/11 1945, at 4 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. L. Sulman M.D.
Medical Examiner.
Date signed 2/13/45

X

G25799

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

99 ✓ Registered No. G25799

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Virginia Ave.
(c) Hospital or institution: Maryland Gen. Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Pygmalion Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Adelia H. Hasselbacher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Charles C. Hasselbacher | 6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) June 22, 887

8. AGE: Years 57 | Months 7 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Washington, D. C. (Town, county, and State)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Louis C. Beckhusen
13. Birthplace Germany

MOTHER 14. Maiden Name Lena Petzel
15. Birthplace Germany

16 (a) Informant Charles C. Hasselbacher
(b) Address 608 Pygmalion Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 13, 1945 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Harry W. Witzke
(b) Address 4101 Edmondson Ave

FEB 13 1945 (b) Washington Boulevard, Md.
Date rec'd by registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1945, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9 1945 to 2/9 1945. and that I last saw her alive on 2/9 1945.

Immediate cause of death: Mesenteric thrombosis — Duration

Due to: 2

Due to: 0

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/9/45

Major findings of operation: Mesenteric venous thrombosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Traynor M. D.

Address Md. Gen'l Hosp. Date signed 2/9/45

625800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1862

625800 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Dr Bayley's office: Belair Rd + Chesterfield Ave. 5/6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4409 Manniota & Bowley Lane (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Helen Kilian

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-2-39

8. AGE: Years 5 | Months 3 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Howard J. Kilian
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Bertha C. Hirsch
15. Birthplace Baltimore Md.

16 (a) Informant Howard J. Kilian (Father)
(b) Address 4409 Manniota ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Lazarus Funeral Home
(b) Address 7401 Belair Rd

19 (a) (b) Registrar

FEB 13 1945
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12, 1945, at 8:30 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-7-45 at A. M.
(b) Where did injury occur? Manniota ave + Bowley Lane
(c) Did injury occur at home, on farm, industrial place, in public place? Outside of home While at work? no
Means of injury Fell while playing.

23. Signature Howard J. Kilian M.D.
Medical Examiner.
Date signed Feb. 12, 1945.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G25801 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 420 Fllecheston Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 —
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 420 Fllecheston Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Byrne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 76 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name James F. Byrne
13. Birthplace Ireland

MOTHER
14. Maiden Name Mc. Roche
15. Birthplace Ireland

16 (a) Informant Mrs Loretta Byrne
(b) Address 420 Fllecheston Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 14 1945 (month) (day) (year)

(c) Cemetery or crematory Cathedral Cemetery
Location —

18 (a) Funeral director Mary M Wiedefeld
(b) Address 501 E. 22nd St

19 FEB 13 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1945, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 19 to July 11 1945, and that I last saw her alive on July 10 19 45.

Immediate cause of death	Duration
Chronic myocarditis	
Due to Acute dilatation heart.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F J Kirby M. D.
Address 110 E North Ave Date signed 2/17/45

625802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. 625802

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3216 Sequoia Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 3216 Sequoia Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wilson [illegible] Eckhardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dorothy Eckhardt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28 1901

8. AGE: Years 43 | Months 1 | Days 15 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Expediter

11. Industry or business Western Electric Co

FATHER
12. Name William Eckhardt
13. Birthplace New York

MOTHER
14. Maiden Name Rose Sedden
15. Birthplace England

16 (a) Informant Alton J. Nichols
(b) Address 114 E Belvedere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 14/1945 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Harry N. Arnaos
(b) Address 4204 Ridgewood Ave

19 (a) Date received by local registrar FEB 13 1945 (b) Signature Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1945, at M

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Illuminating Gas.
Other Conditions Despondency.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8 A. at 2-12-45
(b) Where did injury occur? 3216 Sequoia Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Found in kitchen with all burners on gas stove turned on and open

23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed February 13, 1945

Cover up is especially important. Physicians: please write the causes of death clearly and legibly.

625803

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1604 Registered No. 625803

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Tarner St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Taylor.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	B.	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1945

8. AGE: Years	Months	Days	If less than one day
		18	hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER 12. Name Charles Taylor
13. Birthplace Md.

MOTHER 14. Maiden Name Hengen Sims
15. Birthplace Md.

16 (a) Informant Hosp Record.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL FEB 12 1945
18 (a) Funeral director Commissioner of Health
(b) Address Huntington Williams, M.D.
19 (a) FEB 13 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1945, at 1030 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 1945, to Feb 6 1945, and that I last saw alive on Feb 6 1945

Immediate cause of death	Duration
Intracranial Hemorrhage	Life
Due to Prematurity	
Due to	
Other Conditions Dehydration Pulmonary Edema (Include pregnancy within 3 months of death)	2 days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Leach M. D.
Address Mountcastle, Md. Date signed 2-7-45

VS 150

2509

625804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

625804 Registered No. 3698

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE IN PERMANENT BLACK OR BLUE INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1119 N. Carey
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16'
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 N. Carey
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Amanda Banks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Rev. John D. Banks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1879

8. AGE: Years 65 | Months 4 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Easton Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Mone
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Johns
15. Birthplace Md

16 (a) Informant Eustalia M. Collins
(b) Address 1119 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-45 (month) (day) (year)
(c) Cemetery or crematory Evergreen
Location Balto

18 (a) Funeral director Samuel M. Chase & Son
(b) Address 638 N. Gilmor St.

19 (a) Date received by local registrar FEB 13 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-11-1945, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1-1945, to 2-11-1945, and that I last saw her alive on 2-10-1945.

Immediate cause of death — Duration
Cerebral Hemorrhage — 11 days
Due to
Due to Hypertension Arteriosclerosis — Long
Other Conditions Bronchial asthma
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker Date signed 2-12-45

X

5805

BALTIMORE CITY HEALTH DEPARTMENT X ✓ Registered No. 645805

CERTIFICATE OF DEATH 77E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Smith Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Greenhaven (If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Robert Lee King

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1935

8. AGE: Years	Months	Days	If less than one day
10		15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Philip E. King
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Edna Hunt King
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Philip E. King
(b) Address Greenhaven, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16 45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto Co

18 (a) Funeral director J. F. Flein & Sons
(b) Address Reisterstown Md.

FEB 13 1945 (Date rec'd by registrar) (Huntington Williams, M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1945, at 9:15 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Congestive Cerebral Failure

Due to Ingestion of Ethyl alcohol

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: (over)
(a) Date of injury Feb. 11, 1945 M.
(b) Where did injury occur? Woods at High Point, Pasadena Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? In woods While at work? at play
(d) Means of injury Ingestion of ethyl alcohol

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 2-13-45

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5806 BALTIMORE CITY HEALTH DEPARTMENT G-5806

CERTIFICATE OF DEATH 148B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7212 Holabird Ave
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Helen J. Wingate (WINGATE)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Otto
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-9-1900

8. AGE: Years 44 | Months 7 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business

FATHER
12. Name Edward Fryer
13. Birthplace Baltimore

MOTHER
14. Maiden Name Addie Guthrie
15. Birthplace Baltimore

16 (a) Informant Hospital Chart
(b) Address St Josephs Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location Baltimore

18 (a) Funeral director Philip Herwig Est
(b) Address 2024 Orleans St

19 (a) 2-13-1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9/45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 2/9/45 19 ; and that I last saw her alive on 2/9/45 19 .

Immediate cause of death Myosarcoma of Uterus with metastasis to Lung & mediastinum
Due to
Due to
Other Conditions Terminal Pneumonia
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan L. Calvert M. D.
Address St Josephs Hosp Date signed 2/9/45

VS 150

625807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1172

625807 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address Wagner Ave & Dundalk Ave.
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Boarman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John (John) Edward Stallings (Stallings)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Virginia Stallings
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1913

8. AGE: Years 31 | Months 2 | Days 9 | If less than one day: hr. min.

9. Birthplace: Howard County, Md. (Town, county, and state)
10. Usual Occupation: Pipefitter
11. Industry or business: ship yard

FATHER
12. Name: John Henry Stallings
13. Birthplace: Howard County, Md.

MOTHER
14. Maiden Name: Marie Greenwald,
15. Birthplace: Howard County, Md.

16 (a) Informant: Mrs. Virginia Stallings,
(b) Address: 2903 Boarman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/45 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cemetery
Location: Baltimore County, Md.

18 (a) Funeral director: L. Vernon Lawman
(b) Address: 4611 Park Heights Ave. Huntingtow Pollitsville, Md.

19 (a) FEB 13 1945 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/12 1945, at 1.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/26 1945 to 2/12 1945, and that I last saw h[im] alive on 2/12 1945.

	Duration
Immediate cause of death: Bilateral Pneumonia	2 da
Due to: Gastric ulcer perforation	9 da
Due to: Ulcer	?
Other Conditions: Atelectasis	

(Include pregnancy within 3 months of death)

Date of operation 2/3/45
Major findings of operation: Gastric ulcer & atelectasis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: James A. Dayton M. Dr.
Address: [illegible] Date signed 2/13/45

VS 180

25808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1931 D

Registered No. 25808

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1712 McCulloh St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 McCulloh St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie B. James

3 (b) If veteran, name war

3 (c) ~~Social~~ Security Account No. None

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Wyatt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4 1872

8. AGE: Years 72 | Months 10 | Days 6 | If less than one day hr. min.

9. Birthplace Lancaster C. Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Blackwell

13. Birthplace Va.

MOTHER 14. Maiden Name Julia ? ? ?

15. Birthplace Va

16 (a) Informant Geneva Hood

(b) Address 1712 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-1945 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk

Location Baltimore C. Md.

18 (a) Funeral director Mrs. Carl D. Hartland

(b) Address 1631 Pennsylvania Ave

19 FEB 13 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 1945, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1941, to Oct 10 1945 and that I last saw h.. alive on Jan 21 1945

Immediate cause of death	Duration
2 Arterio-sclerosis	unknown
Myocarditis	unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Bernard Harris M. D.
Address 1207 N Carlton St Date signed Oct 13, 1945

Bernard Harris Oct 13, 1945

VS 150

625809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 625803

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address V
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2133 N Arlington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14 1944

8. AGE: Years | Months 3 1 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm Turner
13. Birthplace Md

MOTHER
14. Maiden Name Viola Hill
15. Birthplace Md

16 (a) Informant Viola Turner (m)
(b) Address 2133 N Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co., Md

18 (a) Funeral director Isaac F. Priester
(b) Address 1018 W Monument St

19 (a) FEB 13 1945 (Date received by Registrar) Thornton for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/23 1945 to 2/9 1945, and that I last saw h[illegible] alive on 2/9 1945

Immediate cause of death Respiratory Failure — | Duration: ?

Due to Medullary compression (?) Intracranial hemorrhage | Duration: 3 wks

Due to Whooping cough (?) | Duration: 1 wk

Other Conditions Bronchopneumonia, Aspiration pneumonia.
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Percy Futterman M. D.
Address Mich Hosp Date signed 2/10

G-25810 G-468566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. G25810

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-4-94

8. AGE: Years	Months	Days	If less than one day
50	2	5.	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name John Harris
13. Birthplace ?

MOTHER
14. Maiden Name Catherine ?
15. Birthplace ?

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Pennsylvania Ave

19 (a) FEB 13 1945 (Date filed by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 1945 at 10:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7. 1945 to Feb 9 1945 and that I last saw h. alive on Feb. 9 1945.

Immediate cause of death	Duration
Peritonitis	
Due to Cancer of the Rectum & Prostate	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2-7-45

Major findings of operation: Obstructed obstruction with Peritonitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Bunch D
Address J. H. H. Date signed 2-11-45

VS 150

Registered by Wilhelmina M. F. Washington

Dr. Peake G25811

BALTIMORE CITY HEALTH DEPARTMENT G25811

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 E. 20th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 East 20th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Linthicum Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Lola Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Anne Arundel Co. Maryland
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Henry Thomas
13. Birthplace A. A. Co., Maryland

MOTHER
14. Maiden Name Nellie Linthicum
15. Birthplace A. A. Co., Maryland

16 (a) Informant Mr. Rodney Thomas
(b) Address 410 East 20th Street

17 (a) Burial (b) Date thereof 2/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) (Signature of Registrar) Huntington Williams, M.D. (b) Registered

FEB 13 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12 1945, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1934 to 2-12 1945; and that I last saw h[illegible] alive on 2-11 1945

Immediate cause of death: Chronic Myocarditis — Duration: 6 Mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Peake M. D.
Address 4508 Harford Rd Date signed 2-12-45

G25812

G25812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2112 Chelsea Terrace
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2112 Chelsea Terrace
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME NELLIE A. MINIER

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widow

6 (b) Name of husband or wife ULYSSES GRANT MINIER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1875

8. AGE: Years	Months	Days	If less than one day
69	8	3	hr. min.

9. Birthplace Waverly, N.Y.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Solomon Cooper
13. Birthplace Milan Penna

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Milan Penna.

16 (a) Informant Miss Kathleen Minier
(b) Address 2112 Chelsea Terrace

17 (a) Burial (b) Date thereof 2/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 118 W. Mt. Royal Ave

FEB 16 1945 Huntington Williams, M.D. Registrar
Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11, 1945 at 6 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/19 1936 to 2/11 1945, and that I last saw her alive on 2/10 1945.

Immediate cause of death	Duration
Arteriosclerotic heart disease	2 mo.
Due to Nephritis	9 yr. ?
Due to Senility	1 1/2 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert A. Reitz M.D.
Address 3408 Windsor Ave Date signed 2/12/45

VS 150

625813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

625813 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3722 Hudson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME S. Eva Zapor (or) Stefania E. Zaporowska
3 (b) If veteran name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Henry J.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2-13-1885
8. AGE: Years 59 | Months 11 | Days 27 | If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name John Rydzynski
13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Rdzynski
15. Birthplace Germany

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 2/14/45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave.
18 (a) Funeral director Stephen J. Fatkenheuer
(b) Address 1060 S. Kenwood Ave.
19 (a) FEB 13 1945 Date of death (month) (day) (year) (b) Attesting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1945 at 10 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1945 to Feb 10 1945 and that I last saw her alive on Feb 10 1945.

	Duration
Immediate cause of death Uremia	8 weeks
Due to Appendix abscess	
Due to	
Other Conditions Ileostomy post operative, accidental (Include pregnancy within 3 months of death)	2 wks

Date of operation January 22 1945
Major findings of operation: Abscess
of autopsy: abdominal (Welch bacillus) Appendix abscess, ileostomy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David B. Cheek M. D.
Address Johns Hopkins Hospital Date signed

VS 150

625814 625814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13 S. Ann St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 S. Ann St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Szymon or Samuel ~~C2rZ19~~ C2rZ19

3 (b) If married, name wife

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1945, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11, 1945, to Feb. 11, 1945, and that I last saw him alive on Feb. 11, 1945.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Josephine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28. 1871

8. AGE: Years	Months	Days	If less than one day
73	3	13	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name ? C2rZ19

FATHER 13. Birthplace Poland.

MOTHER 14. Maiden Name ?

MOTHER 15. Birthplace Poland

16 (a) Informant Julia Wosk

(b) Address 13 S. Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 15 45 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Germantown Hill Rd

18 (a) Funeral director Martin G. Oppel's Son

(b) Address 37 S. Ann St.

19 (a) 2-15-1945 (Date rec'd by registrar) (b) Registrar

Immediate cause of death Myocarditis (chronic) — Duration ?

Due to Arteriosclerosis — Duration ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene L. Cesarone M. D.

Address 514 Druid Lane Date signed 2/12/45

VS 150

Huntington Hollins

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 98

625815 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) -1-
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ----------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2616 Guilford Avenue
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Joanna A. Shanahan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ----------
6 (c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.) ---------- 1858

8. AGE: Years	Months	Days	If less than one day
87	-1-	12	-- hr. --- min.

9. Birthplace Harford County, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name John C. Shanahan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Burke
15. Birthplace Ireland

16 (a) Informant Mrs. Susan S. Kavanagh
(b) Address 2616 Guilford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/45 (month) (day) (year)
(c) Cemetery or crematory St. John's
Location Long Green, Md.

18 (a) Funeral director H. A. Mears and Son
(b) Address 1905 N. Calvert Street

19 (a) (Date rec'd by registrar) FEB 13 1945 (b) Huntington Hill Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11, 1945, at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945, to Feb. 11 1945, and that I last saw her alive on Feb. 8 1945.

Immediate cause of death: Cardiac Fibrillation — Duration: 5 wks
Debility of the Aged
Due to Decubitus
Gangrene R. Foot — 5 Wks
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No.
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Carroll Monmonier M. D.
Address Catonsville Md. Date signed

625816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1931

625816 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1830 Eagle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1838 Eagle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Effie Wright

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	married

6 (b) Name of husband or wife Wm. Wright
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17 1878

8. AGE: Years	Months	Days	If less than one day
66	8	23	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Johnson
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mollie Easton
15. Birthplace Md.

16 (a) Informant Edward Woods
(b) Address 1041 N. Mount St

17 (a) Burial (b) Date thereof Feb 13, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3221 N Schroeder St

19 FEB 13 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10 1945 at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to Arteriosclerotic CV Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature C. J. Sulzinski M.D.
Medical Examiner.
Date signed 2/10/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

G25817 BALTIMORE CITY HEALTH DEPARTMENT G25817 Registered No.

CERTIFICATE OF DEATH 121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address RAYNER + DUKELAND AVE.
(c) Hospital or institution: WEST BALT. GEN. HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 13
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2755 REISTERSTOWN RD
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME REBECCA FRIEDMAN

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873
8. AGE: Years 70 | Months | Days | If less than one day hr. min.
9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Philip
13. Birthplace Russia

MOTHER
14. Maiden Name Hannah
15. Birthplace Russia

16 (a) Informant Melvin Friedman
(b) Address 1240 Ashland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pulaski Hy + Hamilton Ave

18 (a) Funeral director Jack Levis Inc
(b) Address 1439 E. Balt St

19 (a) Date received FEB 13 1945 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1945 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from FEB. 5 1945 to FEB. 13 1945 and that I last saw h.r alive on FEB. 13 1945.

Immediate cause of death UNKNOWN — Duration

Due to

Due to

Other Conditions 1) Cholelethiasis 2) Senility 3) Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation FEB 9 1945

Major findings of operation: (1) RUPTURED APPENDIX (2) LEFT CYSTIC OVARY

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. M. Dienfeld
Address West Balt Gen Hosp Date signed 2nd D. 2/13/45

X

G25818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1640

G25818

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town Richmond (If outside city or town limits, write RURAL and give town)
(d) Street No. 429 Thornton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James G. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years 27 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/45 (month) (day) (year)
(c) Cemetery or crematory
Location Richland Mo.

18 (a) Funeral director John Jr. Weber
(b) Address 404 S. Chester St

19 (a) (Local Registrar) (b) Huntington Williams Registrar

FEB 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11, 45, 19..., at 11:50 A M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Hanging.

Other Conditions –

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-11-45 at 9:45 A. M.
(b) Where did injury occur? S/S THOMAS PAINE PIER # 1 CANTON
(c) Did injury occur at home, on farm, industrial place, in public place? STEAMSHIP While at work? NO.
(d) Means of injury. FOUND HANGING FROM A LADDER IN #4 ESCAPE HATCH.

23. Signature Howard J. Mendelsohn M.D.
Medical Examiner.
Date signed FEBRUARY 12, 1945.

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Type

625819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1972

625819 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 S. Monroe st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Sheffield

3 (b) If veteran, name war: W.

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Clara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13. 1910

8. AGE: Years	Months	Days	If less than one day: hr.	min.
34	6	29		

9. Birthplace Virginia (town, county, and state)

10. Usual Occupation Auto Mechanic

11. Industry or business

FATHER
12. Name Hiram Sheffield
13. Birthplace Va

MOTHER
14. Maiden Name Georgia Unknown
15. Birthplace Va

16 (a) Informant Mrs Clara Sheffield
(b) Address 413 S Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/45 (month) (day) (year)

(c) Cemetery or crematory Charlottesville
Location Charlottesville Va

18 (a) Funeral director Wm Lee Snead
(b) Address 1219 E Grace St

19 (a) FEB 13 1945 (b) [illegible] (By registrar) Registrar

Harrington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12 1945 at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-9 1945 to 2-12 1945, and that I last saw him alive on 2-12 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Acute Alcoholism	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Simmons M. D.

Address Univ. Hospital Date signed 2-12-45

X

G25820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G25820

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 months

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town Long Beach
(If outside city or town limits, write RURAL and give town)
(d) Street No. To East Marker Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME IRVING GALLINGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Gladys.
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1882

8. AGE: Years	Months	Days	If less than one day
62	4 3	2 7	____ hr. ____ min.

9. Birthplace New York City
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Simon Gallinger
13. Birthplace Austria

MOTHER
14. Maiden Name Mary Ellinger
15. Birthplace New York City

16 (a) Informant Mrs. Marie Cohen
(b) Address To E. Marker St. Long Beach NY

17 (a) BURIAL (b) Date thereof 2/16/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Union Field Cem
Location Brooklyn N.Y.
18 (a) Funeral director Chas. E. DeLoach
(b) Address Elcott City
19 (a) FEB 14 1945 (b)
(Date received by registrar) Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1945, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from January 28 1945 to February 13 1945, and that I last saw him alive on February 13 1945.

Immediate cause of death	Duration
Cardiorespiratory failure	
Due to Cardiac decompensation and heart block	
Due to Arteriosclerotic heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frank Suppler, M.D.
Address Union Memorial Hospital Date signed 2/13/45

Huntington Hollander, M.D.

X

G25821 ✓ G25821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No.

Every item of information should be carefully supplied. Please write plainly, with unfading ink. Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address E. 33d Street

(c) Hospital or institution: Union Memorial Hosp. 13

(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3808 Falls Rd. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME James Harrison Steller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Daisy

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1888

8. AGE: Years 57 | Months - | Days 19 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER

12. Name not known

13. Birthplace

MOTHER

14. Maiden Name not known

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 16, 1945 (month) (day) (year)

(c) Cemetery or crematory [redacted]

Location Greencastle, Penna

18 (a) Funeral director Walter Y. Brown

(b) Address Waynesboro, Penna

19 (a) FEB 14 1945 (b) [redacted] Registrar

Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 13 1945, at 4 42 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1945 to Feb. 13 1945, and that I last saw h. alive on Feb. 13 1945.

Immediate cause of death	Duration
Cardio-Resp. Failure	
Due to Hypostatic Pneumonia	
Due to Intestinal Obstruction.	
Other Conditions Obesity	

(Include pregnancy within 3 months of death)

Date of operation Feb. 11, 1945

Major findings of operation: Intestinal obstruction at ileo-caecal region due to adhesions

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Elijah Spragins M.D.

Address U M H Date signed 2-13-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully st... The correct age is especially important. Physicians: please write the... the causes of death clearly and legibly.

625822

YA-91854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

625822 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: BALTIMORE CITY HOSPITALS 26-6

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2½ yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1506 Partridge Court
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1941

8. AGE:	Years	Months	Days	If less than one day
	3	10	2 3	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Millard Thomas

13. Birthplace Va.

MOTHER

14. Maiden Name Elizabeth Epps

15. Birthplace Va.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 2/14/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Burkeville Va

18 (a) Funeral director Elroy C. Wilson

(b) Address 1000 Bland Ave Huntington Williams, Md

19 (a) (b)
(Signature of registrar) Registrar

FEB 14 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11, 1945 at 9:12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 29, 1945, to Feb. 11, 1945 and that I last saw her alive on Feb. 11, 1945.

Immediate cause of death	Duration
Tuberculous Meningitis	1 wk
Due to	
Due to	
Other Conditions Pulmonary T.B.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Warren H. Wright M. D.

Address Baltimore City Hosp Date signed 2-11-45

X Meisels

625823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 625823

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Rutland & Monument St
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2443 Shirley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SLATKOFF, LOUIS

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-708

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Jennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
59 58			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Pants Maker

FATHER
12. Name Max Slatkoff
13. Birthplace Russia

MOTHER
14. Maiden Name Sophie ?
15. Birthplace Russia

16 (a) Informant Jennie Slatkoff
(b) Address 2443 Shirley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 14, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamiltom Ave & Phila Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) FEB 14 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1945, at 9.35 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13 1944 to 2/13 1945, and that I last saw h[illegible] alive on 2/13 1945.

Immediate cause of death	Duration
Pulmonary Edema	
Empyema	
Due to Bronchopleural Fistula	
Hypertensive Arteriosclerotic Heart Disease	
Due to	
Other Conditions Healed Myocardial Infarct Old Coronary Occlusion	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elmer W Braun M. D.
Address Sinai Hospital Date signed 2/17/45

G25824

AB-92071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 105

G25824

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4701 Holabird Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Smith

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9- 1944

8. AGE: Years | Months: 7 | Days: 3 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel Smith
13. Birthplace Penna.

MOTHER
14. Maiden Name Lois Cronon or Cronin
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olive
Location Baltimore Md

18 (a) Funeral director Fullmore Lee & Sons
(b) Address 1217 E Fayette St

19 (a) FEB 14 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12- 1945, at 12.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-11- 1945 to 2-12- 1945, and that I last saw h im alive on 2-12- 1945.

Immediate cause of death — Duration

Bilateral pneumothorax

Due to

Due to

Other Conditions: acute laryngitis & Tracheotomy
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clifton D Gonon jr M. D.
Address BCH Date signed

625825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. 625825

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 Winchester st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Winchester st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carol Jean Fosburg.

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 9 1943

8. AGE: Years	Months	Days	If less than one day
1	2	2	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward L. Fosburg
13. Birthplace England

MOTHER
14. Maiden Name Virginia L. Buchanan
15. Birthplace Balto. Md.

16 (a) Informant Mrs Virginia Fosburg
(b) Address 2910 Winchester St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof Feb 14 1945 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) FEB 14 1945 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11/44 19 to 2/11/45 19, and that I last saw her alive on 2/10/45 19.

Immediate cause of death Sarcoma of Spine — Duration
Due to Sarcoma spine & Lungs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter C. Bacon M. D.
Address 100 E 20th St Date signed 2/12/45

VS 150

625826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 ✓

Registered No. 625826

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be especially important. correct age is

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5912 Arabia Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5912 Arabia Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edmond L. Wright

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced:~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Mildred Wright
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23rd 1900

8. AGE: Years	Months	Days	If less than one day
44	2	20	..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Secretary
11. Industry or business B. O. R. R.

FATHER
12. Name Charles E. Wright
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Rhoda Butt
15. Birthplace Balto. Md.

16 (a) Informant Charles Wright
(b) Address 5912 Arabia Ave

17 (a) Burial (b) Date thereof 2/16/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Oak Lawn
Location Eastern Ave Extended

18 (a) Funeral director Williams Oak Inc
(b) Address 1217 St. Paul St.

19 FEB 14 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1945 at 6:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/12 1945 to 2/13 1945 and that I last saw h~~e~~ alive on 2/12 1945.

Immediate cause of death apoplexy

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? N.D. While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. R. Johnson M. D.
Address 403 Medical Bldg Date signed 2/15/45

X

625827 ✓ 625827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1524 Mt Royal Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 Mt. Royal Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Miller

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, ~~married widowed or~~ divorced. Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 21st 1861

8. AGE: Years 83 | Months 5 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name (Unknown) Miller
13. Birthplace "

MOTHER 14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Mary Parks
(b) Address 1524 Mt. Royal Ave

17 (a) Burial (b) Date thereof 2/15/45
(Burial, ~~cremation or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) FEB 14 1945 (Date rec'd by registrar) (b) Huntington Hollins M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11th 1945 at 10 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944 to 2/11 1945, and that I last saw h[illegible] alive on 2/9 1945.

Immediate cause of death: Pulmonary Edema — Duration 2 days

Due to: Gen. Cardio-Vascular Renal disease — Duration long time

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 1901 Eutaw Pl Date signed 2/13/45 M. D.

X

625828

YA-91871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

625828 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Anne Gallagher

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 11, 1902

8. AGE: Years 42 | Months 8 | Days 30 29 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Home duties

11. Industry or business

FATHER
12. Name John Anderson
13. Birthplace ?

MOTHER
14. Maiden Name Helen Meredith
15. Birthplace ?

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby. 14/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old. Fred. Road. 1 Ed. out

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1700 Eutaw Place

19 (a) FEB 14 1945 (Date rec'd by registrar) (b) Interim for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 1945 at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30, 1945 to Feb. 10 45 and that I last saw h er alive on Feb. 10, 1945.

Immediate cause of death. Meningitis — Duration 12 days

Due to TB? Syphilis?

Due to (over)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.

Address Baltimore City Hospitals Date signed 2-11-45

VS 180

Dr. Gordy
5306 Harford

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

Registered No. G25829

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3004 Echodale Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 Echodale Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Rile

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Margaret Rile
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1855

8. AGE: Years	Months	Days	If less than one day
89	2	27	hr. : min.

9. Birthplace Phila., Pa.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William Rile
13. Birthplace Pa.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. William Rile
(b) Address 3004 Echodale Avenue #14

17 (a) Burial (b) Date thereof 2/16/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory American Mechanics Cem.
Location Phila. Pa.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) Date received by Registrar FEB 14 1945 (b) Huntington Williams M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13, 1945, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Feb 13 1945, and that I last saw h[illegible] alive on Feb 13 1945.

Immediate cause of death	Duration
Bronchopneumonia	12 days
Due to	
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: no
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. L. Cooley M.D.
Address 5106 Harford Rd Date signed 2-13-45

625830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E ✓

Registered No. 625830

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1649 N. Smallwood St
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1649 N. Smallwood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME REBA SILVERSTEIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife MORRIS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name YANKEL
13. Birthplace RUSSIA

MOTHER
14. Maiden Name CHANG
15. Birthplace RUSSIA

16 (a) Informant HERMAN SILVERSTEIN
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-14-45 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location Phila Rd. & HAMILTON Balto

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

FEB 14 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13-45 19 , at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3, 1945 to Feb. 13, 1945 and that I last saw her alive on Feb. 13, 1945.

Immediate cause of death: Pulmonary edema. Cardiac failure. Renal suppression

Duration: 48 hrs.

Due to —

Due to —

Other Conditions Carcinoma of descending colon (?) — about 2 months

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan H. Sprung, M. D.
Address 1810 Eutaw Pl. Date signed 2/13/45.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

625831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

625831 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 713 N. Payson
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 N. Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C. Harvey

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	219-01-4574

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Widow

6 (b) Name of husband or wife Laura Harvey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1872

8. AGE: Years	Months	Days	If less than one day
72	6 5	?	hr. min.

9. Birthplace Vermont
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name George Harvey
13. Birthplace Vermont

MOTHER
14. Maiden Name Julia Roy
15. Birthplace Canada

16 (a) Informant: Mrs. R. W. Hamilton
(b) Address 620 Anneslie Rd.

17 (a) Burial (b) Date thereof 2/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 14 1945
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/11, 1945, at 6 P.M.

21. I certify that I took charge of the remains described above, held an Enquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to b.d. death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Hypertension C.V. Disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Sabin M.D.
Medical Examiner.
Date signed 2/14/45

625832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

625832 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5117 Pembridge Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5117 Pembridge Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA E. CARR

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/22/1879

8. AGE: Years 65 | Months 3 | Days 10 | If less than one day hr. min.

9. Birthplace Wofordsburg, Penna.
(Town, county, and state)

10. Usual Occupation Nurse
11. Industry or business

FATHER
12. Name Charles Albert Carr
13. Birthplace Penna.

MOTHER
14. Maiden Name Lydia Truox
15. Birthplace Penna.

16 (a) Informant Mr. Charles Bloom, nephew
(b) Address 957 Rosedale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/45 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Hancock, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 FEB 14 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12, 1945, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1945, to Feb 12 1945, and that I last saw her alive on Feb 12 1945.

Immediate cause of death	Duration
Coronary Thrombosis	1 hr
Due to Myocardial degeneration	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D.D.McClurken M. D.
Address 31 E Read ave Date signed 2-14-45

X

625833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

625833 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 919. N. Collington Ave.
(c) Hospital or institution:
No
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 919. N. Collington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Wick

3 (b) If veteran, name war	3 (c) Social Security Account No.
Yes	214-20-6688

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15th. 1894

8. AGE: Years	Months	Days	If less than one day
49 50	9 10	26	hr. min.

9. Birthplace Baltimore. Md
(Town, county, and state)
10. Usual Occupation Produce Dealer.
11. Industry or business —

FATHER
12. Name William Wick
13. Birthplace Baltimore. Md

MOTHER
14. Maiden Name Barbara Nagel
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Wick
(b) Address 919 N. Collington Ave,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 15th 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair. Rd.

18 (a) Funeral director Geo. M. Fink & Son.
(b) Address 811. N Wolfe St.

19 FEB 14 1945 (Signature) for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11th 1945, at 10. amM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1944 to Feb. 11 1945 and that I last saw h[illegible] alive on Feb. 11 1945

Immediate cause of death	Duration
Acute Pulmonary Edema & Cardiac Dilatation	2 days
Due to Pul. T.B.	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 3002 E. Baltimore Date signed 2/13/45 M.D.

X

Every item of information should be carefully supplied. Use INDELIBLE PENCIL, WITH UNFADING INK. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

625834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625834 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Belmia ave
(c) Hospital or institution:
Edgewood Old age Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7281. Harford ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Flora M. Weisl

3 (b) If veteran, name war	3 (c) Social Security Account No.
none.	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female.	White	Widow

6 (b) Name of husband or wife Louis Weisl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1862

8. AGE: Years	Months	Days	If less than one day
82 yrs.	9 mo.	1 da.	hr. min.

9. Birthplace Baltimore Md.
(Town, county and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Louis Weisl
13. Birthplace New

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore Md.

16 (a) Informant Mary Krueger
(b) Address 7281. Harford ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 2/14/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location Greenmount ave

18 (a) Funeral director Wendell Hupp
(b) Address 312 S. Highland ave

19 (a) (Date received by registrar) (b) Registrar

FEB 14 1945

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1945 at 9.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 0 1943 to Feb 10 1945 and that I last saw her alive on Feb. 10 1945

Immediate cause of death Chronic Myocarditis — Duration: 1 day

Due to

Due to

Other Conditions Chronic Colecystitis, Chronic Nephritis — Duration: indef

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. A. Rehmeyer M.D.

Address 11 N W. 23rd St Date signed Feb 13 1945

625835

YA-91905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

625835 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 418 S. Eaton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy-McCubbin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 1, 1945

8. AGE: Years | Months | Days: 1 | If less than one day: 29½ hr. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Newborn
11. Industry or business

FATHER
12. Name: Charles McCubbin
13. Birthplace: Kentucky

MOTHER
14. Maiden Name: Barbara Jones
15. Birthplace: Maryland

16 (a) Informant: BALTIMORE CITY HOSPITALS
(b) Address: (RECORDS)

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 2-7-45-9am (month) (day) (year)
(c) Cemetery or crematory: Baltimore City Hospitals
Location: 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (c) FEB 14 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2, 1945, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1 1945, to 2-2 1945, and that I last saw h.e.m. alive on 2-2 1945.

Immediate cause of death: Pneumonia, Aspiration — Duration: 12 hr.
Due to
Due to
Other Conditions Exposure
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. B. Perry, Jr. M.D. M. D.
Address Balto City Hosp. Date signed 2/6/45

625836

AB-91927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

625836

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 23

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 117 W. Hamburg St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2-1945

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Calvin Wall or Colvin Wall

13. Birthplace Ga.

MOTHER

14. Maiden Name Minnie Matthews

15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals (Records

(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 2-7-45: 9am (month) (day) (year)

(c) Cemetery or crematory Baltimore City Hospitals

Location 4940 Eastern Ave

18 (a) Funeral director

(b) Address

19 (a) FEB 14 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4- 1945, at 2.50A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2- 1945 to 2-4 1945 and that I last saw h er alive on 2-4- 1945

Immediate cause of death: Prematurity - 24 mos. wt. 5 lbs.

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature H.B. Runy, Jr. M.D.
M. D.

Address Balto City Hosp Date signed 2/5/45

VS 150

625837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

625837 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 507 N. Stricker St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 507 N. Stricker St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Marvin Clinton.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-5-1906

8. AGE: Years	Months	Days	If less than one day
38	11	6	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business School #119. City

FATHER

12. Name Isaac Clinton

13. Birthplace S. C.

MOTHER

14. Maiden Name Hattie Esler

15. Birthplace N. C.

16 (a) Informant Smithie James

(b) Address 507 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location Baltimore Md

18 (a) Funeral director Watkins & Jackson

(b) Address 916 Pennsa ave

19 (a) (b) Huntington Williamsport, Md

FEB 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1945, at 3. P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1945, to Feb 11 1945, and that I last saw h alive on Feb 11 1945.

Immediate cause of death Pneumonia — Duration 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 2/14/45

G25838 LAKEMAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D ✓ G25838 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1132 May St
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Maggie Lakeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. ✓

6 (b) Name of husband or wife Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 66 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Wilmington N. C.
(Town, County, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name James M. Johnson.
13. Birthplace Petersburg, Virginia

MOTHER
14. Maiden Name Mary Johnson.
15. Birthplace N. C.

16 (a) Informant Mr. Willie Banks.
(b) Address 1132 May St.

17 (a) Burial (b) Date thereof Feb 15 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location.....

18 (a) Funeral director Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) FEB 14 1945 (b) Huntington Pollinger, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/11 1945, at 12 50 M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic CV disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature P. J. Gabrielli M.D.
Medical Examiner.
Date signed 2-14-45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

663839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92E

Registered No. 663839

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 N. Fremont Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto. Md.. (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 N. Fremont Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriett Cooper.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. ✓

6 (b) Name of husband or wife Saml Cooper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 2 1860

8. AGE: Years 84 | Months 1 | Days 8 | If less than one day hr. min.

9. Birthplace Preston, Md.. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Allen
13. Birthplace Hurlock, Md..

MOTHER 14. Maiden Name Tester Homer
15. Birthplace Md

16 (a) Informant Webster Cooper.
(b) Address 104 N. Fremont Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14 '46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Katie R. Williams
(b) Address 322 N. Schroeder St.

FEB 14 1945 (Date filed by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1946 at 4 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1946 to Feb 9 1946 and that I last saw h for alive on Feb 9 1946

Immediate cause of death
(a) Acute Myocarditis
(b) Endocarditis
Due to Bronchial Pneumonia
Due to Debility

Duration
3 days
1 month
10 days

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter F. Cooper M.D.
Address 402 Edmondson Ave Date signed Feb 13 1946

X

6258-40 ✓ 6258-40

BALTIMORE CITY HEALTH DEPARTMENT 95B Registered No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 421 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Phillips

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Christopher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years 34 | Months | Days | If less than one day: hr. min.

9. Birthplace: Columbia S.C. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Jacob Jones
13. Birthplace: Fairfield S.C.

MOTHER
14. Maiden Name: Ellen Young
15. Birthplace: Fairfield S.C.

16 (a) Informant: Christopher Phillips
(b) Address: 421 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 17, 45 (month) (day) (year)
(c) Cemetery or crematory: Columbia, S.C.
Location

18 (a) Funeral director: Katye R. Williams
(b) Address: 322 N. Schroeder St

19 (a) FEB 14 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1945, at 4: A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/6 1945 to 2/12 1945, and that I last saw her alive on 2/12 1945.

Immediate cause of death	Duration
Rheumatic Heart Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. D. Corr M.D.
Address Provident Hospital Date signed 4/13/45

X

625841 ✓ 625841

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47D
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1725 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sally Cox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Strong
13. Birthplace S.C.

MOTHER
14. Maiden Name Ida Rice
15. Birthplace S.C.

16 (a) Informant Relative
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2/15/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Leon A. Walker
(b) Address 1000 Eutaw Pl.

19 (a) Filed 2-13-45 Huntington Williams Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1945 at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1945 to Feb 11 1945 and that I last saw her alive on Feb. 11 1945

Immediate cause of death Carcinoma of Kidney — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus, M.D.
Address Johns Hopkins Hosp. Date signed 2/12/45

X KATTUS

VS 150

625842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 E Registered No. 625842

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1012 Brantley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 Brantley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Mary Robinson
15. Birthplace Md

16 (a) Informant Laurence Johnson
(b) Address 1012 Brantley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

19 (a) (Date rec'd by registrar) FEB 14 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/11/45 at 5:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1944 to 2/11/45.
and that I last saw h[illegible] alive on [illegible] 1945.

Immediate cause of death Myocarditis — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address Date signed 2/12/45

VS 150

625845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. 625845

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly answered. Where there is no information, write NONE. Do not abbreviate. Be sure that age is correctly stated. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2041 Division St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Briscoe

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-14-18

8. AGE: Years	Months	Days	If less than one day
26	4	28	hr. 1918 min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Machine operator
11. Industry or business

FATHER
12. Name Theodore Briscoe
13. Birthplace Md.

MOTHER
14. Maiden Name Mattie Cullison
15. Birthplace Md.

16 (a) Informant Seconds. JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (b) Date thereof 2/16/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Lebanon
Location

18 (a) Funeral director Enos & Wilson
(b) Address 1000 Eutaw St

19 (a) (Date rec'd by registrar) (b) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12 1945, at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-8 1944 to 2-12 1945 and that I last saw h[illegible] alive on 2-12 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Hemorrhage from gastrointestinal tract	5 hrs
Due to Aplastic anemia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature William J. Dixon
Address Johns Hopkins Hosp. Date signed 2/13/45

625844

BALTIMORE CITY HEALTH DEPARTMENT

TN. 92022

CERTIFICATE OF DEATH 108

Registered No. 625844

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Argyle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Plowden or William Plowton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: C.

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1859

8. AGE: Years 85 | Months 1 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Plowden or Plowton
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ("ecords

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-45 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date received by registrar) (b) Registrar

FEB 14 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10, 1945 19 2.10 P.M. at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8, 1945 19 to Feb 10. 1945, and that I last saw h im alive on Feb 10 19 45.

Immediate cause of death: Lobar pneumonia — Duration 2 d

Due to

Due to

Other Conditions Gen arteriosclerosis with Multiple aortic aneurysms — ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Wm Kenneth Smith M. D.
Address Balto. City Hosp. Date signed 2/13/45

G25845

JL - 91983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G25845 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 934 Leadenhall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1886

8. AGE: Years	Months	Days	If less than one day
59	1	3 7	hr. min.

9. Birthplace Oklahoma (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Calvin
13. Birthplace Okla.

MOTHER
14. Maiden Name ?
15. Birthplace Okla.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by local reg.) FEB 14 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1945 at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 8, 1945 to Feb. 10 1945, and that I last saw him alive on Feb. 10 1945

Immediate cause of death: Pulmonary Tuberculosis — Duration: 4 days

Due to:

Due to:

Other Conditions: Ca of esophagus, Anemia, arteriosclerosis — (?)
(Include pregnancy within 3 months of death)

Date of operation 12-11-44

Major findings of operation: Ca. of esophagus (middle third)

of autopsy: Ca above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Dalsheimer M. D.
Address 13 Hamilton, Md Date signed 2-12-45

625846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 625846

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812 N.Pat.Pk.Ave.
(c) Hospital or institution:
7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812 N.Pat.Pk.Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elenora Chilcoat

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Klueber
13. Birthplace Balto.Md.

MOTHER
14. Maiden Name Minnie Degele
15. Birthplace Balto.Md.

16 (a) Informant Miss Hattie Hubbel
(b) Address 812 NP.Pat.Pk.Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15/45 (month) (day) (year)
(c) Cemetery or crematory Balto.Md.Cem.
Location Balto.Md.

18 (a) Funeral director Philip Henrigstans
(b) Address 2024 Orleans St.

19 (a) Feb 14 1945 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb.12/45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1945 to Feb 11 1945 and that I last saw h er alive on 19

Immediate cause of death Carcinoma of Breast — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C B Marck M. D.
Address 801 N Linkrue Date signed 2/13

625847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

625847 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline ST
(c) Hospital or institution St Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 dd.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4102 Granite Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar A. Coulter

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-7272

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mary Coulter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7 1881

8. AGE: Years	Months	Days	If less than one day
63	5	9	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew Coulter
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Sarah —
15. Birthplace Baltimore Md

16 (a) Informant Mrs D. Patzschki
(b) Address 4102 Granite Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 16/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore

18 (a) Funeral director Chilip Henrig Sons
(b) Address 2024 Arlington Ave

FEB 14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13 1945 at 3:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2 1945 to 2-13 1945 and that I last saw him alive on 2-13 1945

Immediate cause of death	Duration
Uremia	
Due to Hypertension	
Due to Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Josephs Hosp Date signed 2-13-45

VS 180

625848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No. 625848

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Providence Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 W. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mary Finney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
45			.....hr. .....min.

9. Birthplace Wilmington, Del.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Gollen
13. Birthplace

MOTHER
14. Maiden Name Mary
15. Birthplace

16 (a) Informant Mrs. Gertrude Finney
(b) Address 716 N. Carey St.

17 (a) Burial (b) Date thereof Feb. 15, 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Zion
Location.....

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 2321 E Lanvale St

19 (a) FEB 14 1945 (b) Penitentiary Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/11 19 45 at 12 30 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry and from the evidence obtained thereon
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature C. J. Pulaski M.D.
Medical Examiner.
Date signed 2/12/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

625849 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Wilmot Ct
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 Wilmot Ct
(If rural give location)
(e) If foreign born, how long in U. S. A.? —— years

3 (a) **FULL NAME** Henrietta Mason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~ Edward Mason

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20 1892

8. AGE: Years 52 | Months 6 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Henry King
13. Birthplace Balto Md

MOTHER
14. Maiden Name Annie Roth
15. Birthplace Altoona Pa

16 (a) Informant Annie Yorkmen Daughter
(b) Address 1211 Wilmot Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14, '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Katie R. William
(b) Address 3209 Pa Schroeder St.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1945, at 7:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to Feb 10 1945, and that I last saw h.. alive on Feb 10 1945.

Immediate cause of death: Carcinoma Lung — Duration: 5 mos

Due to: Metastasis to Lung following Carcinoma Breast

Due to:

Other Conditions: None

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph L. Usserry M. D.

Address 1124 E. Monument Date signed 2/12/45

VS 8

625850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

Registered No. 625850

Please write plainly with pen and ink. The information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 231½ S. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret M. Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Thomas M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18-1881

8. AGE: Years	Months	Days	If less than one day
63	8	25	24 hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Unknown
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Delia A. Thompson
(b) Address 819 Uhetta Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15-1945 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director Pratt C. & B. M. Walters
(b) Address Pratt & Stricker Sts

19 (a) Date rec'd by local reg. FEB 14 1945 (b) Waiting for Filing Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1945, at 4 17 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Lev death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Multiple fractures
Septicemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/1

(a) Date of injury 6:45 A.M. 12-7-44
(b) Where did injury occur? Wilkens Ave. & Uhetta Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian struck by automobile

23. Signature Thomas J. Medairy M.D.
Medical Examiner.
Date signed 2-12-45

625851 TH.

SUBJECT TO APPROVAL BY MEDICAL EXAMINER
BALTIMORE CITY HEALTH DEPARTMENT

91578

CERTIFICATE OF DEATH ✓ 126

625851 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- month
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Warner St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Sewell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10-1900

8. AGE: Years	Months	Days	If less than one day
45		3	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clarence Sewell (D
13. Birthplace Maryland

MOTHER
14. Maiden Name Nettie McGlotten
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof 2-17-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A. Hayes
(b) Address 142 W. Fielb St

19 (a) FEB 14 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13, 1945 19 at 10.45 A.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12-45 19 to 2-13-45 19, and that I last saw her alive on 2-13-45 19.

Immediate cause of death: Respiratory Paralysis — Duration: 30 min
Due to: Cardiac Arrest — "
Due to: Spinal Anaesthesia — over
Other Conditions: Cholecystitis Diabetes — ?
(Include pregnancy within 3 months of death)
Date of operation: not completed
Major findings of operation: " "
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: Drowning Examination
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. M. Cunningham M. D.
Address Balto City Hosp. Date signed 2-14-45

For P. H. McNally, by Howard F. Madden, M.D.

VS 150

G25852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1159

Registered No. G25852

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 836 W. 37th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME (Baby Boy Walter) Stanfield Eugene Walter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 4, 1945

8. AGE: Years | Months | Days 8 9 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Corp Stanfield Walker
13. Birthplace Maryland

MOTHER 14. Maiden Name Charlotte Susan Fisher
15. Birthplace Maryland

16 (a) Informant Mrs. Charlotte Walter
(b) Address 836 W. 37th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14-1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Perrin
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3691 Falls Road

19 (a) FEB 14 1945 (Date received by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1945 at 12:30 A M

21. I certify that death occurred on the date above stated: that I attended deceased from Feb 5 1945 to Feb 13 1945; and that I last saw him alive on Feb 13 1945

Immediate cause of death Cardio-respiratory Failure — Duration 10 min

Due to Septicemia

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Brigitte Nelson
Address Union Memorial Hosp Date signed 2/13/45

VS 150

625853 AB-91675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 625853

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1373 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mabel Bonner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31- 1898

8. AGE: Years 46 | Months 3 | Days 11 12 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Bonner
13. Birthplace Va.

MOTHER
14. Maiden Name Alma Jackson
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 2- 45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md.

18 (a) Funeral director Wm. Geo. E. Holland
(b) Address 1401 Eutaw Place

19 (a) FEB 14 1945 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12- 1945 at 7.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19 1945 to 2-12 1945, and that I last saw h er alive on 2-12- 1945.

	Duration
Immediate cause of death uremia	1 mo. ?
Due to arteriolar nephrosclerosis	3 mo ?
Due to	
Other Conditions hypertensive cardiovascular disease; anemia, secondary; obesity	

Date of operation
Major findings of operation:
of autopsy? no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Perry M.D.
Address City Hosp. Date signed 2-13-45

VS 180

G25854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G25854
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 2248 Annapolis Ave
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2248 Annapolis Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver J Lowman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Anna Lowman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5 1874

8. AGE: Years	Months	Days	If less than one day
70	10	7 6	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Iron Worker
11. Industry or business

FATHER
12. Name Denton Lown
13. Birthplace Md

MOTHER
14. Maiden Name Don't know
15. Birthplace Md

16 (a) Informant Rev G E Lowman
(b) Address 3602 Alameda Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem
Location Anne Arundel Co Md

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 (a) FEB 14 1945 (b) Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 11th 1945, at 8 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jany 1945, to Feby 11 1945, and that I last saw h alive on Feby 11 45

Immediate cause of death	Duration
Acute Cardiac failure	3 hrs
Due to Cardio vascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dan McKeeffer M. D.
Address 2470 Mad. Ave Date signed 2-12-45

Huntington Williams, M.D.

VS 150

4644620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625855

Registered No. 180a

Every item of information should be carefully answered; write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2102 Bolton St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Charles Ramsee.

3 (b) If veteran, name war: W.W. 1

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-13-99

8. AGE: Years	Months	Days	If less than one day
45	7	30 29	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business

FATHER 12. Name Charles. Ramsee

13. Birthplace Md.

MOTHER 14. Maiden Name Mary Rentz.

15. Birthplace Md

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-45 (month) (day) (year)

(c) Cemetery or crematory Meadowridge Mem Park

Location Elkridge, Md.

18 (a) Funeral director H. Howard Strong

(b) Address 3209 W. North Ave.

19 (a) FEB 14 1945 (Date rec'd by local reg.) (b) Huntington Williams, M.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 1945 at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1944 to Feb 12 1945, and that I last saw him alive on Feb 12 1945.

Immediate cause of death	Duration
Brain abscess	
Due to Pneumococcic streptococcus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Multiple visceral abscesses

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Albert A. Hatten M.D.

Address Johns Hopkins Hosp Date signed 2/15/45

VS 180

625856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 85

625856 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Boone St
(c) Hospital or institution: 9th

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 Boone St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret C. Dutton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14/1922

8. AGE: Years 22 | Months 6-3 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John E. Dutton
13. Birthplace Md

MOTHER
14. Maiden Name Ollie Hawkins
15. Birthplace Washington D.C.

16 (a) Informant Ollie Dutton
(b) Address 2601 Boone St

17 (a) Burial (b) Date thereof 2 15 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location Arlington

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) (b) Huntington Nitkauski
(Date rec'd by registrar) Registrar

FEB 14 1945

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-11- 1945, at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8, 1945, to Feb 11, 1945, and that I last saw h[illegible] alive on 2-11-45

Immediate cause of death STATUS EPILEPTICUS — Duration 1 da

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Nothing Remarkable

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marie Adams M. D.
Address 312 E. 23rd Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25857 G25857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2214 Hunter ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Carter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/15/1896

8. AGE: Years	Months	Days	If less than one day
48 y 9	10	24	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation porter
11. Industry or business

FATHER
12. Name Carter
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Va

16 (a) Informant Brence Carter
(b) Address 1616 Madison AVE.

17 (a) Burial (b) Date thereof 2 15 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bath National
Location Baltimore

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) FEB 14 1945 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1945, at 10:15 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Hemorrhage due to gunshot of neck & chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-9-45 at 10 A. M.
(b) Where did injury occur? 2214 Hunter ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Gun-Shot (three times) Firearm.

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed February 10, 1945

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625858 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct. Age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3004 Ruckert Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 Ruckert Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Willingham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of ~~husband or~~ wife Mary Burke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7 1864

8. AGE: Years 80 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Carriage Painter (Retired)

11. Industry or business

FATHER 12. Name Benj. Willingham

13. Birthplace Md.

MOTHER 14. Maiden Name Anne McGreevy

15. Birthplace Md.

16 (a) Informant Miss Gertrude Willingham

(b) Address 3004 Ruckert Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Balto.

18 (a) Funeral director C. D. Fanning & Son

(b) Address 1938 E. Lafayette Ave.

FEB 14 1945 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 1945, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to 2/12 1945, and that I last saw h~~e~~ alive on 2/12 1945.

Immediate cause of death (Duration)
(a) Chronic Myocarditis.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Michael J. Foley M.D.
Address 5703 Harford Rd. Filed 2/14/45

G25859

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 181

G25859
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
or City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 705 Stirling Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 65 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 12 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 14 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 1945, at 7:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
2nd-3rd° Burns 80% of Body

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 26 at 4:30 P.M.
(b) Where did injury occur? 705 Stirling Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Fell asleep smoking

23. Signature John R. Davis M.D.
Medical Examiner
Date signed 1/26/45

F 2511

625880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 625880

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13 W. Fort Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 W. Fort Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James William Douglas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife Anna Douglas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1900

8. AGE: Years 44 | Months 4 | Days 24 23 | If less than one day hr. min.

9. Birthplace North Umberland Co, Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Thomas Henry Douglas

FATHER 13. Birthplace Nord Umberland Co., Va.

MOTHER 14. Maiden Name Mary Lee Jackson

MOTHER 15. Birthplace Richmond Co., Va.

16 (a) Informant Anna Douglas

(b) Address 13 W. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-45 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cem

Location Annapolis Md.

18 (a) Funeral director John J. Duda.

(b) Address 2229 Hudson St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

FEB 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1945, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Enquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature C. J. Lubinski M.D.
Medical Examiner.

Date signed 2/12/45

C. J. Lubinski

466560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

625861 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2539 Fait Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Casper Raszubski

3 (b) If veteran, name war

3 (c) Social Security Account No. 21501-4265

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Mildred.
6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) 1-9-05

8. AGE: Years	Months	Days	If less than one day
40	1	3	hr. min.

9. Birthplace md. (Town, county, and state)
10. Usual Occupation Barber.
11. Industry or business

FATHER 12. Name Marion Casper
13. Birthplace Poland.

MOTHER 14. Maiden Name Josephine Z.
15. Birthplace Poland

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb-15-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Md

18 (a) Funeral director Phil. J. Dyda
(b) Address 2829 Hudson Street

19 (a) (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb-12- 1945, at 12.16 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1945 to Feb 12 1945, and that I last saw him alive on Feb-12 1945.

Immediate cause of death	Duration
Syphilitic heart disease with aortic insufficiency	
Due to Angina pectoris due to syphilitic aortitis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert C. Kattus
Address Johns Hopkins Hosp. Date signed 2/15/45

VS 1946 FEB 14 1945

625862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

625862
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County Camden
(c) City or town Merchanville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Park Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME (Axel) Alex J. Rosenquist

3 (b) If veteran, name war: no
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Helen Alice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1878

8. AGE: Years	Months	Days	If less than one day
66	3	6	hr. min.

9. Birthplace Sweden
(Town, county, and state)
10. Usual Occupation Master Tug
11. Industry or business New York Port Embarkation

FATHER
12. Name --
13. Birthplace Sweden

MOTHER
14. Maiden Name --
15. Birthplace Unknown

16 (a) Informant Mr. Jack Heinz
(b) Address Merchanville, N. J.

17 (a) Removal (b) Date thereof 2/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington National
Location Arlington, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 19 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 6

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13, 1945, at M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry thereon and from the evidence
(Autopsy or Inquiry)
obtained by said Inquiry find that said deceased came
(Autopsy or Inquiry)
to natural death on the day stated above.

Immediate cause of death Coronary Thrombosis

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Knight B. McNally M.D.
Medical Examiner.
Date signed 2/14/45

JL - 91715 G25863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

98

G25863 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: BaltimoreCity Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 622 S. Rose St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Eckert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1865

8. AGE: Years	Months	Days	If less than one day
79	7	27	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Gutfrieb
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina
15. Birthplace Germany

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Feb. 15/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Carmel Cem.

Location Baltimore City

18 (a) Funeral director John M. Weber

(b) Address 404 S. Chester Street

19 (a) FEB 14 1945 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11. 1945 at 1.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 20 1945, to Feb. 11 1945, and that I last saw him alive on Feb. 11 1945.

	Duration
Immediate cause of death: Hypostatic pneumonia	36 hrs.
Due to: Arteriosclerotic Gangrene	1 wk.
Due to: Generalized arteriosclerosis	5 wks.
Other Conditions	?

(Include pregnancy within 3 months of death)

Date of operation 2-5-45, 1-27-45

Major findings of operation: Gangrene

of autopsy: Pneumonia, pul. infarction

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Hauck E. Bolton M.D.

Address Balto. City Hosp. Date signed 2/14/45

G25864 BALTIMORE CITY HEALTH DEPARTMENT G25864
Registered No.

CERTIFICATE OF DEATH 107

The information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 731 S. Ann St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 731 S. Ann Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Liberia Colbert

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 31 1944

8. AGE: Years	Months	Days	If less than one day
	9 8	11	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Colbert
13. Birthplace Washington D. C.

MOTHER
14. Maiden Name Lottie Wright
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Lottie Colbert
(b) Address 731 S. Ann Street

17 (a) Burial (b) Date thereof Feb 15 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) (b)
(Date rec'd by Registrar) Registrar

FEB 14 1945 Huntington Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12- 1945, at 3.35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 2-13-45

G25865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G25865 V48B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4411 N. Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4411 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Frances Ellen Donnelly

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Francis X. Donnelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Washington, N.J. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hugh Allen
13. Birthplace Stroudsburg, Pa.

MOTHER
14. Maiden Name Stella A. Brennan
15. Birthplace St. Andrews Canada

16 (a) Informant Hugh A. Meade
(b) Address 109 E. Melrose Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/45 (month) (day) (year)
(c) Cemetery or crematory St. Ann's
Location Hampton, N. J.

18 (a) Funeral director H. K. Meares & Son
(b) Address 805 N. Calvert St.

Date 2 14 1945 (By) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/12 1945 at 10P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10 1942 to 2/12 1945, and that I last saw h[illegible] alive on 2/10 1945

Immediate cause of death: Carcinoma of Uterus — Duration

Due to: with Peritoneal

Due to: 17 Bed Sores

Other Conditions: Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank Heagler M. D.
Address 3047 St. Paul St. Date signed 2/14/45

X

VS 150

G25866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G25866

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1725 Cole Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 M
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1725 Cole Street (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Eleanora Stauffer

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Harry L. Stauffer
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) March 1, 1872

8. AGE: Years	Months	Days	If less than one day
70	11	13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Julius Winder
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Schmidt
15. Birthplace Maryland

16 (a) Informant Harry L. Stauffer
(b) Address 1725 Cole Stet

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 15 1945 (Month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director Leo H. Schwab
(b) Address 2104 Frederick Avenue

FEB 15 1945

19 (a) (Date rec'd by registrar) (b) Huntington Williams Hyatt

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1945, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944, to 2-13-1945, and that I last saw h[illegible] alive on 2-12 1945.

Immediate cause of death: Carcinoma descending Colon — Duration ?
Due to: —
Due to:
Other Conditions Kidney stone — ?
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature Morris B. Schreider M. D.
Address 54 S. Fulton Ave Date signed 2-13-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 625867

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3228 Leeds Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 41yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3228 Leeds Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Wilson

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 216-03-9836

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Sadie Wilson

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) January 28, 1874

8. AGE: Years	Months	Days	If less than one day
71	—	16	hr. min.

9. Birthplace Chester, Pennsylvania
(Town, county, and state)

10. Usual Occupation Stationary Engineer

11. Industry or business Penny Smith & Co.

FATHER
12. Name John Wilson
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary Mc Mecken
15. Birthplace Scotland

16 (a) Informant Mrs. Sadie Wilson
(b) Address 3228 Leeds Street

17 (a) Burial (b) Date thereof Feb. 17-1945
(Burial, cremation, or removal) (month) (day), (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director Geo. W. Schwab
(b) Address 2101 Fredrick Ave.

19 (a) Embalmer Huntington Williams
(b) Address

FEB 15 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13, 1945, at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to Feb 13 1945.
and that I last saw h[illegible]M alive on Feb 13 1945.

Immediate cause of death: Coronary Occlusion — Duration: 5 hrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J M Collins M. D.
Address 3301 Fred. Ave Date signed 2-13-45

X

625868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625868 Registered No.

JO #91970

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 12
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sam Oldich

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1888

8. AGE: Years	Months	Days	If less than one day
56	11	22	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Dan
13. Birthplace Russia

MOTHER
14. Maiden Name Pauline Abick
15. Birthplace Russia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL FEB 14 1945

18 (a) Funeral director Commissioner of Health
(b) Address
19 FEB 15 1945 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7, 1945, at 4:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5, 1945, to Feb. 7, 1945, and that I last saw him alive on Feb. 7, 1945.

Immediate cause of death coronary occlusion — Duration 5 min.?
Due to
Due to
Other Conditions hypertensive cardiovascular disease, decompensated (Include pregnancy within 3 months of death)
Date of operation gastro-intestinal erosion
Major findings of operation:
of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C.A. Perry, M.D.
Address City Hosp. Date signed 2-10-45

VS 150

2513

625869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

625869 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Wilmer
(b) Street address 747 ~~Gilmor~~ Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 747 Gilmor Court
(If rural, give location)
(e) If foreign born, how long in U. S. A.? Wilmer years

3 (a) FULL NAME Baby Girl Boyd Boyd.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race B | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2/13/45
8. AGE: Years | Months | Days 1 | If less than one day hr. min.
9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ben Junior Hall
13. Birthplace Columbus, Ala.

MOTHER
14. Maiden Name Sara Elizabeth Boyd
15. Birthplace Baltimore, Md.

16 (a) Informant Sara Elizabeth Boyd
(b) Address 747 Gilmor Court

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL FEB 14 1945
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) FEB 15 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14 1945 at 12 30 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 2/13/45 19 to 2/14/45 19.
and that I last saw her alive on 2/14/45 19.
Immediate cause of death Respiratory Failure
Due to Prematurity
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration
1 Day

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature James L. Shuttle M. D.
Address Univ. Hosp. Date signed 2/15/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 8

(231)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~625870~~ BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 625870

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 726 Edgewood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 726 Edgewood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCES MARIA HAWKINS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Allen J. Hawkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1860

8. AGE: Years	Months	Days	If less than one day
84	2	14	hr. min.

9. Birthplace West Moreland Co., Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John H. Conner
13. Birthplace Va.

MOTHER
14. Maiden Name Mildred A. --
15. Birthplace Unknown

16 (a) Informant Mr. J. Irvin Bien
(b) Address 726 Edgewood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 15 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1945 to 2/12 1945 and that I last saw ~~her~~ alive on 2/12 1945

Immediate cause of death Bronchopneumonia — Duration 2 day
Due to
Due to
Other Conditions Hypostatic Arterio Sclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. A. Cohen M. D.
Address 2145 W. Balto. St. Date signed 2/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 625871

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3020 Garrison Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 Garrison Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH PLAENKER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Frederick Plaenker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1865

8. AGE: Years	Months	Days	If less than one day
79	5	12	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Baltz
13. Birthplace St. Louis, Mo.

MOTHER
14. Maiden Name Mary Gehb
15. Birthplace Baltimore

16 (a) Informant Mrs. Marie L. Spranklin
(b) Address 3020 Garrison Blvd.

17 (a) Burial (b) Date thereof 2/16/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 15 1945 (b) Huntington Williams M.D.
(Date received by local registrar) Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Feb. 13, 1945, at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1942 to Feb 12 1945, and that I last saw h alive on Feb 12 1945

Immediate cause of death	Duration
Chronic myocarditis	10 yr
Due to Arteriosclerosis	15 yr
Due to	
Other Conditions Cerebral Accident (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature
Address 3403 Date signed 2/14/45

VS 180

G25872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92E

Registered No. G25872

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 N. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GRACE ELIZABETH EVANS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles H. Evans
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 9, 1878

8. AGE: Years	Months	Days	If less than one day
67	0	3	hr. min.

9. Birthplace Elkridge, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Gustavus W. Hobbs
13. Birthplace Frederick Co., Md.

MOTHER
14. Maiden Name Jeanette D. Richardson
15. Birthplace Washington, D. C.

16 (a) Informant Mr. Clark S. Hobbs
(b) Address 2904 Montebello Terr.

17 (a) Burial (b) Date thereof 2/15/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 15 1945 (b) Huntington Williams M.D.
(Date rec'd by local Reg.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12, 1945 at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1936 to Feb-12 1945.
and that I last saw h[illegible] alive on Feb-12-1945.

Immediate cause of death	Duration
(a) Pneumonia	
Due to (b) Endocarditis	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter W. Rich M. D.
Address 3005 Park St. Date signed 2-14-45

VS 180

X

625873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 625873

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4604 York Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4604 York Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Charlotte Hull

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife George A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/17/70

8. AGE: Years 74 | Months 11 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick Hennegen
13. Birthplace Europe

MOTHER
14. Maiden Name Wilhelmina Wagner
15. Birthplace Baltimore

16 (a) Informant Mrs. Wm. H. Lewis
(b) Address 5820 Royal Oak Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16.45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) FEB 15 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1945 at 11:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 31 1944 to Feb 13 1945 and that I last saw h alive on Feb 13 1945

Immediate cause of death Pneumonia, influenzal — Duration 6 wks

Due to

Due to

Other Conditions Carcinoma of breast metastatic to bones. — Duration 1 yr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. C. Chesfant, M.D.
Address 6710 York Rd Date signed Feb 15 1945

33a

VS 150

625874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 625874

1. PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address 1010 Tack Pl.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 4 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County Blair Co.
(c) City or town Altoona
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 Chestnut Ave
(If rural give location)
(e) Citizen of foreign country? non (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Hooper

3 (b) If veteran, name war —

3 (c) Social Security Account No. 181-14-0305

4. Sex fem | 5. Color or race white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife James B. Hooper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6. 30. 1877

8. AGE: Years 67 68 | Months 7 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Arbitonia Pa.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business —

FATHER
12. Name Henry Gordon
13. Birthplace Arbitonia Pa.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Susan Wagner
(b) Address 1010 Tack Pl. Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/45 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Altoona Pa.

18 (a) Funeral director Wilhoyte Funeral Home
(b) Address 2704 Pontiac

19 (a) FEB 15 1945 (Date rec'd by registrar) (b) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-15-1945, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1. 15. 1945 to 2. 15 1945 and that I last saw her alive on 2. 14. 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	5 days
Due to Hypertensive Cardiovascular disease	2
Due to	
Other Conditions Auricular fibrillation	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: /
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ... at ... M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature M. J. Summers M. D.
Address 1045 Pleasant Ave. Date signed 2.15.45

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G25875

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2927 Keswick Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2927 Keswick Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mark Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Ida E. Williams

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Mar. 20, 1871

8. AGE: Years 73 74 | Months 10 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Balto City Highways

FATHER
12. Name Thomas Williams
13. Birthplace Md

MOTHER
14. Maiden Name Sophie Smith
15. Birthplace Md.

16 (a) Informant Ida E. Williams
(b) Address 2927 Keswick Rd.

17 (a) Burial (b) Date thereof 2-15-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto Co.

18 (a) Funeral director Lehnerwitz + Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) (b) Huntington Wilkinson
Date rec'd by Registrar

FEB 15 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1945, at 8:15 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~my~~ knowledge death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. B. McKelvey M.D.
Medical Examiner.

Date signed 2/14/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 625876

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 N. Spring St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 N. Spring St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Quickley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/19/1882

8. AGE: Years 63 | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Isaac Quickley

13. Birthplace md

MOTHER 14. Maiden Name Eliza P

15. Birthplace md

16 (a) Informant Georgiana Jones

(b) Address 1814 N. Spring St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A. A. County

18 (a) Funeral director Raymond Sanders

(b) Address 1412 E. Preston Street

19 (a) FEB 15 1945 (Date received by Local Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 · 12 1945 at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1945 to Feb 12 1945, and that I last saw h~~im~~ alive on Feb 12 1945.

Immediate cause of death: Pulmonary edema — Acute Myocarditis — Duration 24 hours

Due to: Lobar Pneumonia — 3 days

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. L. Seery M. D.

Address 1420 E. Chase Date signed 2-15-45

X

G25877 ✓ G25877

BALTIMORE CITY HEALTH DEPARTMENT 93D Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2606 Jefferson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Jefferson St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Charles Weidner

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Lena Weidner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11/1866

8. AGE: Years 78 | Months 8 | Days 3 2 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation --
11. Industry or business

FATHER
12. Name John Weidner
13. Birthplace Unknown

MOTHER
14. Maiden Name Catherine--
15. Birthplace Unknown

16 (a) Informant Mr. George Weidner
(b) Address 2606 Jefferson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) FEB 15 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13/45 19 ... at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17 1938 to 2/13 1945 and that I last saw h[illegible] alive on 2/10 1945.

Immediate cause of death	Duration
(a) Myocarditis	6
Due to (b) Hypertension & Atherosclerosis	2
Due to (c) Senility	?
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis J. Klumes M. D.
Address 2623 E. Monument Date signed 2/14/45

REMEMBER: WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55 E 625878 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 407 N.Lakewood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 407 N.Lakewood Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Frank J.Wagner

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Clara Wagner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.28/1899

8. AGE: Years 45 | Months 11 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Martin Wagner
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Awelia Farve
15. Birthplace Miss

16 (a) Informant Mr.Martin Wagner
(b) Address 407 N.Lakewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb.16/45 (month) (day) (year)

(c) Cemetery or crematory Moreland Mem.Park
Location Balto.Md.

18 (a) Funeral director Philip Young Sons
(b) Address 2024 Orleans St.

19 (a) FEB 17 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb.12/45 19 , at 3P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb.5 19 45 to Feb.12 1945 and that I last saw him alive on Feb 12 19 45

Immediate cause of death: Acute Cardiac Failure — Duration: 1 day

Due to: Carcinoma of the Bronchial glands — 1 1/2 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Biopsy at City Hospital-1 year ago
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Israel Rozen M.D.
M. D.
Address 2413 E Monument Date signed 4/19/45

VS 8

Please write plainly in ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

625879 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Rosedale
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8329 Old Phila. Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Wallace

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/13/45

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace 8329 old Philadelphia Rd. Maryland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Roy E. Wallace
13. Birthplace Mo.

MOTHER 14. Maiden Name Lillie M. Riggsby
15. Birthplace Tenn.

16 (a) Informant R. E. Wallace
(b) Address 8329 Old Phila Rd

17 (a) Burial (b) Date thereof 2/16/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lansdowne Cemetery
Location Balto Co. Md

18 (a) Funeral director Lansdowne Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 1 FEB 15 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14 1945, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13 1945 to 2-14 1945, and that I last saw her alive on 2-14 1945.

Immediate cause of death Prematurity

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Stabler M. D.

Address Md. Genl. Hospital Date signed 2/14/45

X

466865. BALTIMORE CITY HEALTH DEPARTMENT 46 B 625830
CERTIFICATE OF DEATH Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Md~~ Va. (b) County
(c) City or town Arlington (If outside city or town limits, write RURAL and give town)
(d) Street No. 4320 N. Old Dominion Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert Reynolds.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male. 5. Color or race: White. 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Josephine. 6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) 9-10-99

8. AGE: Years 45 | Months 5 | Days 3 | If less than one day: hr. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual Occupation Pt. U.S. Fed. Police

11. Industry or business

FATHER 12. Name Charles Reynolds

13. Birthplace D.C.

MOTHER 14. Maiden Name Annie Sebastian

15. Birthplace D.C.

16 (a) Informant Reynolds.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 15 45 (month) (day) (year)
(c) Cemetery or crematory Washington D.C.
Location Washington

18 (a) Funeral director Wareham & Sherwood
(b) Address Washington D.C.

19 (a) FEB 15 1945 (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1945, at 10.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 21 1944, to Feb 13 1945, and that I last saw him alive on Feb. 13 1945.

Immediate cause of death Bilateral pneumonia — Duration 5 days

Due to General cachexia — 2 mos

Due to Carcinoma of the head of pancreas — 6 mos

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/13/45

Major findings of operation: Suppurative carcinoma of head of pancreas

of autopsy: Ascites & bilateral pneumonia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Handelsman M.D.
Address Johns Hopkins Date signed 2-14-45

625831 RAUTOAKINA ✓ 625881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet St.
(c) Hospital or institution:
Pronounced dead at City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Unknown (b) County
(c) City or town Unknown
(If outside city or town limits, write RURAL and give town)
(d) Street No. Unknown (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country France

3 (a) FULL NAME Josephine Telephore Rautoanina (Antonia Telephores)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Unknown

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1905

8. AGE: Years 40 | Months ? | Days ? | If less than one day ... hr. ... min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation
11. Industry or business U. S. Pure Food.

FATHER
12. Name Alphonse Di Antionia
13. Birthplace Marseilles, France

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Responsible effects Unknown
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director E. Willis Lamoreaux
(b) Address 1003 W. Baltimore

19 (a) ... (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

FEB 15 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10-1945, at 11a. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Found drowned in harbor.

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... 1/1 M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work?
Harbor. #1 Pier P.R.R. Canton
(d) Means of injury

23. Signature Seward E. Miller M.D. Medical Examiner.
Date signed 2/11/45

X

correct age is especially important. Physicians: please write the

625832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

464

Registered No. 625832

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1552 Northgate Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Agnes A. Canton. (Agnus A. Canton)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Eugene Canton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 21, 1900.

8. AGE: Years	Months	Days	If less than one day
44	11 10	14 24	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Edward Enzmann.
13. Birthplace Balto.

MOTHER
14. Maiden Name Agnes McDonald.
15. Birthplace Maryland.

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (b) Date thereof 2/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.
18 (a) Funeral director H. W. Means and Son
(b) Address 805 N. Calvert Street
19 (a) FEB 15 1945 (Date rec'd by Registrar) (b)

Huntington for Williams M.K.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14 1945 at 12:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 1945 to 2/14 1945, and that I last saw her alive on 2/13 1945.

Immediate cause of death	Duration
Cardio-Resp failure	
Due to Generalized abdomenal Carcinomatosis	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2/1/45
Major findings of operation: Malignant implant on peritoneum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl R Patterson M. D.
Address Mercy Hosp Date signed 2/14/45

X

883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30D

Registered No. 665883

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution:
University 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and name county)
(d) Street No. 597 Baker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Farrell

3 (b) If veteran, name war WW I

3 (c) Social Security Account No. 213-16-6188

4. Sex M

5. Color or race Col

6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/3/1888

8. AGE: Years 56 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Joseph A. Farrell
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Mitchell
15. Birthplace Md.

16 (a) Informant Anthony Farrell
(b) Address 4306 Clifton Ave

17 (a) Burial (b) Date thereof 2/17/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto. National
Location Md.

18 (a) Funeral director Wm. H. Kelson
(b) Address 1303 Pennsylvania Ave

FEB 15 1945 (b) Hunterston Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1945, at 6 55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to 19..., and that I last saw h... alive on 19....

Immediate cause of death	Duration
Compression fracture	
Due to Anemia & Pernicious Anemia	
Due to Lupus Carcinomatosis Lungs	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Palmer M. D.
Address University Hospital Date signed 2/14/45

VS 150

625884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 625884

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dot
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and name town)
(d) Street No. 1105 E. Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matthew McCoy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Callie McCoy

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 3-19-1890

8. AGE: Years 54 | Months 10 | Days 21 | If less than one day ... hr, ... min.

9. Birthplace Fayetteville N. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John McCoy
13. Birthplace N. C.

MOTHER
14. Maiden Name Lena ?
15. Birthplace N. C.

16 (a) Informant: Callie McCoy
(b) Address 1105 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A.A.Co. Md.

18 (a) Funeral director Bryson Francis & Knight
(b) Address 72 Walbrook St

FEB 15 1945 (Date rec'd by registrar)
(b) Huntingtown, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10 1945, at 9:30 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. Galbraith M.D.
Medical Examiner.
Date signed 2/12/45

VS 151

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

625835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B Registered No. 625835

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Mercy Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 0 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116½ Aisquith St.
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country.....

3 (a) FULL NAME William Johnson, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Mary Johnson
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) April 26 1898

8. AGE: Years	Months	Days	If less than one day
46	9	16	..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Wm. Johnson, Sr.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mamie Boone
15. Birthplace Balto. Md.

16 (a) Informant Mamie Blackledge
(b) Address 116½ Aisquith St.

17 (a) Burial (b) Date thereof 2-15-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. Co. Md.

18 (a) Funeral director Bryson & Mamie H. Knight
(b) Address 721 Aisquith St.

19 (a) FEB 15 1945 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1945, at 2:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Stomach

Due to.....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Mendes M.D.
Medical Examiner.
Date signed 2-12-45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G65886

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 N. Paca Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Bratcher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1874

8. AGE: Years 70 | Months 10 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name Bratcher
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mrs. Sarah I. Gross
(b) Address 603 N. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 FEB 15 1945 (b) Huntington Wilson (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 | 13 1945, at 10:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 | 9 1945, to 2 | 13 1945, and that I last saw him alive on 2 | 13 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. R. Conway, M. D.
Address Provident Hospital Date signed 2 | 13 | 45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G65857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 160 Winters Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kingston Pye

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Frances Pye
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1904

8. AGE: Years	Months	Days	If less than one day
40	2	17	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Charles Pye
13. Birthplace Md.

MOTHER
14. Maiden Name Lottie ?
15. Birthplace Md.

16 (a) Informant Mrs. Frances Pye
(b) Address 160 Winters Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-45 (month) (day) (year)
(c) Cemetery or crematory Western Star Cem.
Location Baltimore Co., Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150 FEB 15 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1945; at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1945, to 2/12 1945, and that I last saw him alive on 2/12 1945.

Immediate cause of death Malignant Hypertension — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. R. Cooney M.D.
Address Provident Hospital Date signed 2-12-45

G25838
468805

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124a

Registered No. G25838

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3803 Barrington Road
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country NO

3 (a) FULL NAME Sybilla Gross (SYBILLA WEIGAND GROSS)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Milton (H. Milton Gross)
6 (c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): 10-25-91 1890

8. AGE: Years	Months	Days	If less than one day
54 (53)	3	19	hr. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual Occupation: Home-wife
11. Industry or business

FATHER
12. Name: Philipp F. Weigand
13. Birthplace: Germany.

MOTHER
14. Maiden Name: Barbara Hedy Volz
15. Birthplace: Germany

16 (a) Informant: Records.
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16, 1945 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 108 W. North Av. (W. F. Wooden-Suc.)

19 (a) FEB 15 1945 (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH Feb-13 1945, at 8:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-12 1945 to Feb 13 1945 and that I last saw h[illegible] alive on Feb-13 1945.

	Duration
Immediate cause of death: Heart Failure	10 days
Due to: Profound Anemia	?
Due to: Alcoholic cirrhosis of the liver	?
Other Conditions: Obesity	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurence Dickson Jr. M.D.
Address Johns Hopkins Date signed 2/14/45

G25833

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. G25833

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1423 Bolton St
(c) Hospital or institution: at home 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 64yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltstaty
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1423 Bolton St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mary Warner Kirkbride Miller

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Daniel Miller
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July-7-1858

8. AGE: Years 86 | Months 7 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Missouri (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Jonathon Kirkbride
13. Birthplace U. S. A.

MOTHER
14. Maiden Name Mary Warner
15. Birthplace U. S. A.

16 (a) Informant E. Kirkbride Miller (son)
(b) Address 4809 Roseworth Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 104 W. NORTH AVENUE

FEB 15 1945 (b) Date received by registrar — Registrar for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1945, at 2 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1928 to 2/13 1945, and that I last saw her alive on 2/13 1945.

Immediate cause of death: Coronary Thrombosis — Duration 1 hr
Due to: Myocarditis — Arterio-sclerosis — Evidence
Due to: —
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature W. H. Moody, M. D.
Address 1403 Park Ave Date signed 2/14/45

VS 150

G25890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G25890

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2313 E. Biddle Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2313 E. Biddle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE HANSEN

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emil Hansen

6 (c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): June 4.1876

8. AGE: Years: 68 | Months: 8 | Days: 9 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: Louis Staib
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: unknown
15. Birthplace: Germany

16 (a) Informant: Mr. Emil Hansen
(b) Address: 2313 E. Biddle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-45 (month) (day) (year)
(c) Cemetery or crematory: Western
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, Inc.
(b) Address: North Ave • Broadway

19 (a) FEB 15 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1945, at 11.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1941 to 2/13 1945 and that I last saw her alive on 2/13 1941.

Immediate cause of death: Hypertensive Cardio-Vascular disease — Duration:
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Charles Flowe
Address 3215 Eastern Ave Date signed 2/14/45 M.D.

VS 150

G25891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1314 Registered No. G25891

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the cause of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4009 Maine Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4009 Maine Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter L. Imbach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth,

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) June 4-1881

8. AGE: Years 63 | Months 8 | Days 8 | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business

FATHER
12. Name Frank Imbach
13. Birthplace Switzerland

MOTHER
14. Maiden Name Mary Shildell
15. Birthplace Ireland

16 (a) Informant Elizabeth Imbach
(b) Address 4009 Maine Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb-16-45 (month) (day) (year)
(c) Cemetery or crematory New Cathy
Location Old Frederick Road

18 (a) Funeral director Orland E. Indan
(b) Address 3000 E. Balto. St.

19 FEB 15 1945 (b) Date received by local registrar Huntington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1945, at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1943, to Feb 1945, and that I last saw h[illegible] alive on Feb 12 1945.

Immediate cause of death: Cerebral embolus — Duration

Due to: Cardio-vascular renal disease — Duration

Due to: Hypertension and Nephritis — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Wolnick

Address 4710 Liberty Hts Date signed 2/13/45 M. D.

VS 150

625892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B Register No. 625892

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 21E. Hughes Street (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Julius Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-7543

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/12/1904

8. AGE: Years 41 | Months - 1 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Brown
13. Birthplace NC

MOTHER
14. Maiden Name Katie Thomas
15. Birthplace N.C.

16 (a) Informant Della Worley
(b) Address 21 E Hughes Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co Md

18 (a) Funeral director Isaiah L Brown Sr
(b) Address 108 W Montgomery St

19 (a) FEB 15 1945 (Date rec'd by registrar) (b) Interring for Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14, 1945 at 3 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Dec death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Stomach

Due to.....

Other Conditions Syphilis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Howard J. Masters M.D. (Medical Examiner.)
Date signed 2-16-45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13B

Registered No. 625893

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: University Hospital 4

(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County N
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 642 W. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME James Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 1, 1923

8. AGE: Years	Months	Days	If less than one day
22	-	10	..... hr. ..... min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Stewart
13. Birthplace Balto

MOTHER
14. Maiden Name Mable Barnett
15. Birthplace Balto

16 (a) Informant Annie Green
(b) Address 642 W Fairmount Ave

17 (a) Burial (b) Date thereof 2/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location a. a. Co Md

18 (a) Funeral director Isaiah L Brown & Son
(b) Address 108 W Montgomery St

19 (a) FEB 15 1945 (b) [illegible]
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11, 1945 - 12:50 at A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Tuberculosis

Due to .....

Other Conditions Tuberculosis of myocardium.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury.....

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed February 17, 1945.

VS 151

correct age is especially important. Physicians: please write the ... the causes of death clearly and legibly.

625894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 625894

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 808 China ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Always

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 808 China ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Brenda Owens

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col —	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15 1944

8. AGE: Years	Months	Days	If less than one day
—	4	28	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Owens
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margaret Owens
15. Birthplace Baltimore Md

16 (a) Informant Charles Owens
(b) Address 808 China ave

17 (a) Buried (b) Date thereof 2/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co Md

18 (a) Funeral director Isaiah F. Brown
(b) Address 108 W Montgomery St

19 FEB 15 1945 Huntington Williams, M.D.
Date received by Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1944 at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1944 to Dec 13 1944, and that I last saw h alive on Dec 12 1944.

Immediate cause of death	Duration
acute Bronchopneumonia	
Due to Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature David Franklin M. D.
Address 1112 Lee ave Date signed 12/13/44

5762

G25895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G25895

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 2711 Fait Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2711 Fait Ave
(If rural give location)
(e) Citizen of foreign country? I (Yes or No)
If yes, name country

3 (a) FULL NAME John Stez

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-09-4511

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife 11

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2-1880

8. AGE: Years	Months	Days	If less than one day
64	11	12	hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation Team Driver

11. Industry or business Cantor Cumb Co

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr Andrew Sadler
(b) Address 2711 Fait Ave

17 (a) Burial (b) Date thereof Feb 17-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md

18 (a) Funeral director Walter Sokolosky
(b) Address 394 S. Hanover St

19 (a) FEB 15 1945 Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 1945, at 6:00 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to h.d. death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. J. Turbinski M.D.
Medical Examiner.
Date signed 2/17/45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly

G25896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G25896 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 119 N. Carrollton
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 N. Carrollton
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Hunt.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Helen Hunt
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Nov - 1 - 1880

8. AGE: Years 64 | Months 3 | Days 10 | If less than one day hr. min.

9. Birthplace Annapolis Md
(Town, county, and state)

10. Usual Occupation Drug Dealer
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Elizabeth Hunt
15. Birthplace Annapolis Md

16 (a) Informant Helen Hunt
(b) Address 961 Bennett Pl

17 (a) Burial (b) Date thereof Feb. 15, '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Katie R. William
(b) Address 322 N. Schroeder St

19 (a) FEB 19 1945 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 11 1945, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1945, to Feb 11 1945, and that I last saw h ~~alive~~ on Feb 11 1945.

Immediate cause of death Pulmonary Tuberculosis — Duration 6 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 2/14/45

X

G-5897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G-5897

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Montgomery
(c) City or town Silver Spring (If outside city or town limits write RURAL and give town)
(d) Street No. 8401 Old Bladensburg Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sandra Lee Cooley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-7-44

8. AGE: Years	Months	Days	If less than one day
	6	7	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Earl Cooley
13. Birthplace Maryland

MOTHER
14. Maiden Name Ruth Denton
15. Birthplace Maryland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17, 1945 (month) (day) (year)
(c) Cemetery or crematory Montgomery Cemetery
Location Bethesda, Md.

18 (a) Funeral director Gibson & Walters
(b) Address 7 Harrell St. Takoma Park, D.C.

FEB 15 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1945, at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1945 to Feb. 14 1945 and that I last saw h[illegible] alive on Feb. 14 1945.

Immediate cause of death: Tuberculous meningitis — Duration

Due to: Pulmonary tbc, history

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Birmingham M. D.
Address JHH Date signed 2-14

VS 150

625898

HEALTH DEPARTMENT—CITY OF BALTIMORE

625898

CERTIFICATE OF DEATH

No social security no.

83a

1. PLACE OF DEATH

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1400 Hull St., Ward)

Length of residence in city or town where death occurred yrs. mos. 4 da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Stephen Nicholas Goetz

If U. S. Veteran specify WAR

(a) Residence: No. 1400 Hull St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White	married

5a. If married, widowed or divorced HUSBAND of (or) WIFE of Wanda Goetz

6. DATE OF BIRTH (month, day, year) Aug. 19, 1901

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	7	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Tavern Keeper

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Rumania

FATHER

13. NAME Stephen Goetz

14. BIRTHPLACE (city or town) (State or country) Rumania

MOTHER

15. MAIDEN NAME Julia Popovitch

16. BIRTHPLACE (city or town) (State or country) Rumania

17. INFORMANT Mrs. Wanda Goetz

(Address) 1400 Hull St. Cem.

18. BURIAL, CREMATION, OR REMOVAL Cypress Cem.

Place Burial, Holy Date Feb 16 19 45

19. UNDERTAKER Chas. F. Dill

(Address) 1521 E. Fort Ave.

20. FILED 19

Registrar.

FEB 15 1945

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb. 13, 1945

22. I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1945, to 2-13, 1945

I last saw him alive on 2-12, 1945. Death is said to have occurred on the date stated above, at 7:11 A. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	2-12-45
arteriosclerosis	1937
Other contributory causes of importance:	

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) A. J. Ballard, M. D.

(Address) 707 E. Fort Ave.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Explanations on back of certificate.
OCCUPATION is very important. See instructions on back of certificate.

VS 8

X

625899

BALTIMORE CITY HEALTH DEPARTMENT

JO #91259

CERTIFICATE OF DEATH 94 a

625899 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 20 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Matthew Bridges

3 (b) If veteran, name war —

3 (c) Social Security Account No. ?

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1876 ?

8. AGE: Years	Months	Days	If less than one day
68?	1 ?	22 ?	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Robert Bridges (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Acker (d)
15. Birthplace France

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 15-45 (month) (day) (year)
(c) Cemetery or crematory First United Evang
Location 6115 Gilmor[illegible]

18 (a) Funeral director John J. Gaeblinger Jr
(b) Address 423 S. Paca St.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 15 1945 Lemington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15, 1945, at 11:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 23, 1944 to Feb. 13, 1945 and that I last saw h im alive on Feb. 13, 1945

Immediate cause of death: Myocardial infarction — Duration: 1 day

Due to: coronary sclerosis — Duration: 5 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon

Address Balto. City Hosp. Date signed 2/15/45 M. D.

625900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625900 V 83 a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3604 Harlem Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3604 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jay Walter Haulman

3 (b) If veteran, name war

3 (c) Social Security Account No 008 01 0011

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Emma F. (nee Elgert)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1884.

8. AGE: Years	Months	Days	If less than one day
61	1	-	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Rutland Fire Clay Co.

FATHER
12. Name Alison M. Haulman
13. Birthplace Pa.

MOTHER
14. Maiden Name Elizabeth Bringel
15. Birthplace Pa.

16 (a) Informant Mrs. Emma F. Haulman
(b) Address 3604 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16/45. (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

FEB 15 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13/45. 19 ... at 9 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to Sept 1944, and that I last saw him alive on Sept. 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration 5 hrs

Due to: Arteriosclerosis & hypertension — 1½ yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. E. Wells.
Address 4100 Edmondson Ave Date signed 2/14/45 M. D.

Approved: Hugh B. McNally M.D.
per Robert Lee Graham M.D. X

625901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 4 6E

Registered No. 625901

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Greene & Lombard Sts

(c) Hospital or institution:

Univ. Hospital 8 2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) 70

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County 4

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2 Bethel ave (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME George Roeth

3 (b) If veteran, name war none

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Margaret Roeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28, 1860

8. AGE: Years 84 Months 8 Days 14 If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Tinner

11. Industry or business

FATHER

12. Name —— Roeth

13. Birthplace Germany

MOTHER

14. Maiden Name unknown

15. Birthplace Germany

16 (a) Informant Wm. N. Roeth

(b) Address 4305 Liberty Heights

17 (a) BURIAL (b) Date thereof 2-15-45 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory PARKWOOD

Location HARFORD and TAYLOR AVE

18 (a) Funeral director Harry A. Witzke

(b) Address 4101 Edmondson Ave

19 (a) (b) (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14 1945 at 12:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1945 to 2-14 1945 and that I last saw h alive on 19.

Immediate cause of death	Duration
Cardiac insufficiency	
Due to arteriosclerosis	
Due to	
Other Conditions Ca of colon	

(Include pregnancy within 3 months of death)

Date of operation 2-10-45

Major findings of operation: Ca of sigmoid

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. H. Young M. D.

Address Greene & Lombard Date signed 2-16-45

FEB 16 1945 Huntington Williams, M.D. Registrar

VS 150

X

625902

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1931

625902
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4108 Curtis Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4108 Curtis Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Pastorek Pastoek

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John Pastoek

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) May 5. 1878

8. AGE: Years 66 | Months 9 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace Gerkslovickesi (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Unis
13. Birthplace Unkown

MOTHER
14. Maiden Name Unkown
15. Birthplace

16 (a) Informant John Pastoek
(b) Address 4108 Curtis ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Blvd

18 (a) Funeral director Thos. J. Kenny
(b) Address Collins & Gilroe

19 (a) FEB 15 1945 (b) (Date rec'd by registrar)

Registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13, 1945 at 3:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Davis M.D.
Medical Examiner.
Date signed 2/13/45

X

625903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 625903

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address James
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 mins
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 E. Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John George Schmeisser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Augusta M.E. Schmeisser

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) May 20, 1878

8. AGE: Years 66 | Months 8 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Henry Schmeisser
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine ——
15. Birthplace Germany

16 (a) Informant Mrs. Augusta Schmeisser
(b) Address 1613 48 Rhode Island Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd.

19 (a) FEB 16 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1945, at 3:22 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1945 to Feb. 14 1945
I last saw him alive on Feb. 14 1945

	Duration
Immediate cause of death: Cardio respiratory failure	
Due to: Arteriosclerotic heart disease	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melchizedek Spraggins M. D.
Address UMH
Date signed 2-14-45

X

625904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

149 A

Registered No. 625904 (over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University of Md.
(c) Hospital or institution: Green & Redwood Sts
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Bel Air Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Guy King

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years 38 | Months | Days | If less than one day ....hr. ....min.

9. Birthplace (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Landon Bishop

13. Birthplace

MOTHER 14. Maiden Name Margie Ball

15. Birthplace

16 (a) Informant Joan T. Foster

(b) Address Bel Air Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby. 17/45 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Bel Air Md.

18 (a) Funeral director John O. Mitchell & Sons

(b) Address 1900 Eutaw Place

19 (a) ..... (b) ..... (Signature of local registrar)

FEB 16 1945 Huntingtown Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-15 1945, at 7 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12 1945 to 2-15 1945 and that I last saw h[illegible] alive on 2-14 1945

Immediate cause of death Traumatic enterocutaneous vesico vaginal & utero vaginal fistulae & Uretro peritoneal herniation — Duration 3-5 days

Due to Child birth

Due to .....

Other Conditions Fault presentation infancy Pulmonary congestion - hyper uterus at 3-5 days

(Include pregnancy within 3 months of death)

Date of operation 2-12-45

Major findings of operation: Ruptured uterus and cervix, and retroperitoneal [illegible]

of autopsy: [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. O. Hammond M. D.

Address Gen. Hospital Date signed 2-15-45

625905

AB-91960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

Registered No. 625905

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 151

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1420 N. Parrish St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mattie Handy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30- 1895

8. AGE: Years	Months	Days	If less than one day
49	4	7 6	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James

13. Birthplace Md.

MOTHER 14. Maiden Name Julia Sudrick

15. Birthplace Md

16 (a) Informant Baltimore City Hospitals (Records.

(b) Address 4940 Eastern Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location JOHNS HOPKINS MEDICAL SCHOOL FEB 14 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 FEB 15 1945 (Date rec'd by registrar) (b) [illegible] Registrar 2518

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6- 1945, at 8.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5- 1945, to 2-6 1945, and that I last saw her alive on 2-6- 1945.

Immediate cause of death	Duration
Bronchio-pneumonia	12 hrs
Pulmonary atelectasis	
Due to Carcinoma of ovary &	?
metastases & lungs	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. J. Perry

Address BCH Date signed 2-13-45 M.D.

VS 150 approved: TO BE APPROVED BY THE MEDICAL EXAMINER
Hugh B. Mechally M.D. per Robert Lee Graham M.D.

625906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

625906 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully furnished. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or days~~) 11 days
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3100 Kenyon Ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Czechoslovakia

3 (a) **FULL NAME** Agnes Radek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anton Radek

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/6/88

8. AGE: Years 56 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Vaclav Vysusil
13. Birthplace Czech.

MOTHER
14. Maiden Name Unknown
15. Birthplace n

16 (a) Informant Husband
(b) Address 3100 Kenyon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/45 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (Registrar's signature) (b) Huntington Williams, Registrar

FEB 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1945, at 9.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1945 to 2/13 1945 and that I last saw her alive on 2/13 1945.

Immediate cause of death: Coronary Occlusion — Duration

Due to: Arteriosclerotic heart disease.

Due to:

Other Conditions: Left hemiplegia Cerebral hemorrhage (old)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ac. Cardiac Failure

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Seaver, M. D.
Address St. Joseph's Hosp. Date signed 2/13/45

625907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625907
Registered No.

JO #90858

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2710 White Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Anna Marie Thune

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Henry (d)
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 15, 1887
8. AGE: Years 57 | Months -6- | Days 28 | If less than one day hr. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Joseph Benda
13. Birthplace: Czechoslovakia

MOTHER
14. Maiden Name: Barbara Maliec or Malik
15. Birthplace: Czechoslovakia

16 (a) Informant: Bessie Dannenfelser
(b) Address: 403 S. Angelsea Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/45 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore, Md.

18 (a) Funeral director: Charles E. Schimunek
(b) Address: 2601 E. Madison Street

19 (a) (Date rec'd by registrar) FEB 15 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15, 1945, at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 27, 1944, to Feb. 13, 1945, and that I last saw her alive on Feb. 12, 1945.

	Duration
Immediate cause of death: Broncho pneumonia	7 days
Due to:	
Due to:	
Other Conditions: Rheumatic heart disease & mitral stenosis	7

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: E Woodward M. D.
Address: Baltimore City Hospitals Date signed: 2-15-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

107

D of 2 Filed
2318 Eastern Ave

625908

BALTIMORE CITY HEALTH DEPARTMENT 625908

CERTIFICATE OF DEATH

Registered No. 115 B

Every item of information should be carefully written. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age is especially important. PRESS WHITE PLATES, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 Springfield ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 Springfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christo Vassalis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18, 1931

8. AGE: Years	Months	Days	If less than one day
13	11	14 2/6	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Nicholas Vasilas

13. Birthplace Greece

MOTHER 14. Maiden Name Stella Lerios

15. Birthplace Greece

16 (a) Informant Mrs Nicholas Vasilas

(b) Address 709 Springfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/1945 (month) (day) (year)

(c) Cemetery or crematory Greek Orthodox

Location Windsor Mill Rd.

18 (a) Funeral director Lambros Chas.

(b) Address 440 E. North Ave.

19 (a) [illegible] (b) Huntington Williams M.D.

(Date rec'd by registrar) FEB 15 1945 Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1945, at 8 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1945 to Feb 14 1945, and that I last saw him alive on Feb 12 1945.

Immediate cause of death	Duration
Acute Cardiac dilatation	Immediate
probable Pulmonary Embolism	30 days
Due to Epilepsy	
Due to	
Other Conditions Streptococcus throat infection	Feb 6

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank N Zierler M. D.

Address 2318 Eutaw Place Date signed 2/15/45

85

625909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

625909 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Monerich Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Renna.

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife –

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1870

8. AGE: Years 74 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Co.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Frederick Renna
13. Birthplace U.S.A.

MOTHER
14. Maiden Name Mary King
15. Birthplace U.S.A.

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-45 (month) (day) (year)
(c) Cemetery or crematory St Johns.
Location Ellicott City Md.

18 (a) Funeral director F.C. Negenbotham
(b) Address Ellicott City Md

19 (a) (b) Huntington Williams Registrar
(Date of this registration)

FEB 15 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1945, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1945, to Feb 14 1945, and that I last saw him alive on Feb 14 1945.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Cerebral Hemorrhage	2 days
Due to Arterio Sclerosis	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 163 E-North Ave Date signed Feb 16 46

X

625910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 625910

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1632 W. Fayette Street
(c) Hospital or institution: Fayette Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 N. Monroe St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Adelaide Fowler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) November 19, 1860

8. AGE: Years 84 | Months 2 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Westminster, Carroll County, Md. (Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business Retired

FATHER
12. Name Louis A. Fowler
13. Birthplace Maryland

MOTHER
14. Maiden Name Louisa Bowersox
15. Birthplace Maryland

16 (a) Informant Louise Kohler
(b) Address 333 Martingale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16, 1945 (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Westminster, Md.

18 (a) Funeral director Geo L. Schwab
(b) Address 201 Frederick Avenue

19 FEB 16 1945 Interment for Williams Agent Dir.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 19 45, at 1:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1944 to Feb 13 1945, and that I last saw h 21 alive on Feb 13 1945.

	Duration
Immediate cause of death Myocardia Insufficiency	2da
Due to Cerebral Hemorrhage	1 yr
Due to Cardio Vascular disease	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl Toms M. D.
Address 1202 St Paul St Date signed 2/13/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6-5911 BALTIMORE CITY HEALTH DEPARTMENT ✓ 6-5911
CERTIFICATE OF DEATH 131a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2102 Wilkins Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 Wilkins Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Rose Schneider Henger.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Christian Henger
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) December 10, 1888

8. AGE: Years 56 | Months 2 | Days 4 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Charles Wall
13. Birthplace Maryland

MOTHER 14. Maiden Name Kolflish
15. Birthplace Maryland

16 (a) Informant Mrs. Thelda Chaney
(b) Address 2102 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Hugh Schaal
(b) Address 2686 Frederick Ave.

19 FEB 16 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1945, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1945, to Feb. 14 1945, and that I last saw her alive on Feb. 14 1945.

Immediate cause of death Hypertension-C.V.D. Disease-Hemeplegia-Arteriosclerosis-Chronic Nephritis. — Duration
Due to
Due to
Other Conditions Pulmonary Oedema.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Tulloch M.D. M. D.
Address 2151 Wilkens Ave Date signed 2-14-45

X

625912

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

54a

Registered No. 625912

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood and Greene
(c) Hospital or institution: University of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days): 4da
(e) Length of stay in Baltimore (yrs., mos., or days): ?

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Washington
(c) City or town: Smithsburg
(If outside city or town limits, write RURAL and give town)
(d) Street No.: —
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Ruth Ridenour

3 (b) If veteran, name war: —

3 (c) Social Security Account No.: —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem.	White	Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): — 1890

8. AGE: Years	Months	Days	If less than one day
55	—	—	— hr. — min.

9. Birthplace: Md
(Town, county, and state)

10. Usual Occupation: —

11. Industry or business: —

FATHER
12. Name: Samuel Ridenour
13. Birthplace: Md

MOTHER
14. Maiden Name: Anne Stephan
15. Birthplace: Md

16 (a) Informant: father Samuel Ridenour
(b) Address: Smithsburg Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb 18 1945 (month) (day) (year)
(c) Cemetery or crematory: Smithsburg Cemetery
Location: Smithsburg Md.

18 (a) Funeral director: Walter G. Grove
(b) Address: Waynesboro Pa.

19 FEB 16 1945 (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-15 1945, at 3:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12 1945, to 2-15 1945, and that I last saw h[illegible] alive on 2-15 1945

Immediate cause of death	Duration
Hypothermia	
Due to medullary compression	
Due to glioma brain tumor	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation: 2-13-45

Major findings of operation: glioma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Kenneth M. Boone M. D.
Address: Main St. Date signed: 2-15-45

X

VS 150

625913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

625913
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St + Rutland Ave
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2350 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Blumberg.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Paul Blumberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Jacob Cohen
13. Birthplace Russia

MOTHER
14. Maiden Name Diva —
15. Birthplace Russia

16 (a) Informant Paul Blumberg
(b) Address 2350 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-45 (month) (day) (year)
(c) Cemetery or crematory United Hebrew Cem
Location Wash. Blvd.

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St.

FEB 16 1945 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1945 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 1945 to Feb 15 1945, and that I last saw h.e.r alive on Feb 15 1945.

Immediate cause of death	Duration
Sub dural Hematoma (due to)	
Thrombocytopenia (due to)	
Carcinomatosis (due to)	
Primary in Stomach	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Ca of Stomach

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Brown M. D.
Address Sinai Hospital Date signed 2/15/45

VS 150

625914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

625914 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument st & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Herring Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Belle Rosenfeld

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Samuel J. Rosenfeld

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1919

8. AGE: Years	Months	Days	If less than one day hr.	min.
26				

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Isaac -
13. Birthplace Russia

MOTHER
14. Maiden Name Metta -
15. Birthplace

16 (a) Informant Samuel J. Rosenfeld
(b) Address 374 N. Patt. Pl. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-45 (month) (day) (year)
(c) Cemetery or crematory Sinai Memorial Park
Location

18 (a) Funeral director Jos Levin Inc
(b) Address 1439 E. Balto St

19 (a) FEB 16 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 19 45 at 7:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 19 45 to Feb 15 19 45 and that I last saw h e alive on Feb 15 19 45

Immediate cause of death	Duration
Myocardial Failure	
Due to Rheumatic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Rheumatic Heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Brown M. D.
Address Sinai Hosp Date signed 2/15/45

625915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94B

Registered No. 625915

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4808 Park-Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-18
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ****
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4808 Park-Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. Ernest Clark

3 (b) If veteran, name war --

3 (c) Social Security Account No. 220-12-0717

4. Sex Female

5. Color or race Wht.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Erma E. Clark

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) May 18, 1882

8. AGE: Years 62 | Months 8 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Church-Hill Md. (Town, county, and state)

10. Usual Occupation Farmer & Butcher

11. Industry or business

FATHER
12. Name Wm. Clark
13. Birthplace Church-Hill Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mrs. Erma E. Clark
(b) Address 4708 Park-Heights 15

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 17, 1945 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

19 (a) FEB 16 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION 10.45

20. DATE OF DEATH Feb. 14 1945, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1945 to Feb 14 1945, and that I last saw him alive on Feb 14 1945

Immediate cause of death	Duration
Angina Pectoris	2/12/45
Due to	
Due to Arteri Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hans D Bubert M. D.
Address 4803 Park Heights Ave Date signed 2/15/45

VS 150

625916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

625916

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1143 Carroll Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Mc Kelden

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Emma V. Mc. Kelden

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Feb 4. 1887

8. AGE: Years	Months	Days	If less than one day
58	0	10	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Sheet Metal Worker

11. Industry or business

FATHER
12. Name James Mc. Kelden
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Dora Greif
15. Birthplace Baltimore Md.

16 (a) Informant Emma V. Mc. Kelden
(b) Address 1143 Carroll St.

17 (a) Burial (b) Date thereof Feb. 17 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location City

18 (a) Funeral director Jno. Nels. John W. Teufel & Son
(b) Address 801 W. Fayette St.

19 (a) FEB 16 1945 (b) Harrington Williams M.D.
(Date received by registrar) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14- 1945 at 9 a. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 2-14-45

VS 151

X

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

625917 ✓ 625917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5602 York Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 ~~1~~ 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5602 York Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph W. Scott

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Dorothea E. Scott

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) July 12. 1869

8. AGE: Years	Months	Days	If less than one day
75	7	2	hr. min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation Store Keeper

11. Industry or business Dry Goods & Notions

FATHER
12. Name Benjamin F. Scott
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary R. Mullin
15. Birthplace Ireland

16 (a) Informant Dorothea E. Scott
(b) Address 5602 York Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location City

18 (a) Funeral director Wm. Mks. John W. Teufel & Son
(b) Address 801 W. Fayette St.

19 (a) FEB 16 1945 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1945, at 9 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1, 1944 to Feb 1 1945, and that I last saw him alive on Feb 13 1945.

Immediate cause of death	Duration
Cardiac dilatation	minutes
Due to Cachexia	3 1/2 mos.
Due to Squamous cell carcinoma, Larynx	13 1/2 mos
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation July, 1944 - Biopsy

Major findings of operation: Biopsy - Squamous cell Carcinoma

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A Wagner M. D.
Address 406 Cedarcroft Rd Balto. Md. Date signed Feb. 14, 1945

625918

HEALTH DEPARTMENT—CITY OF BALTIMORE

625918

CERTIFICATE OF DEATH ✓ 927

1. PLACE OF DEATH

Registered No. .....

CITY OF BALTIMORE: (No. 515 Jasper St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Eleanora A. Tibbs (Tibbs) Jessie

If U.S. Veteran specify WAR .....

(a) Residence: No. 515 Jasper St., 17th Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Tibbs

6. DATE OF BIRTH (month, day, year) 1884

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
61	—	—	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Clerk

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) (State or country) Baltimore

FATHER

13. NAME Geo. Smedley

14. BIRTHPLACE (city or town) (State or country) Md

MOTHER

15. MAIDEN NAME Emma Carr

16. BIRTHPLACE (city or town) (State or country) Md.

17. INFORMANT William Tibbs

(Address) 515 Jasper St.

18. BURIAL, CREMATION, OR REMOVAL

Place Mt Calvary Cem Date Feb. 17 1945

19. UNDERTAKER Mrs. Robert A. Elliott & Daughter

(Address) 1129 N. Caroline St.

20. FILED FEB 16 1945 Thurlington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb. 14 1945

22. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1945 to Feb. 13, 1945

I last saw h[illegible] alive on Feb 13 1945 Death is said to have occurred on the date stated above, at 5.30 A.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Valvular Disease	
Heart	
Other contributory causes of importance:	

Was an operation performed? ..... Date of .....

For what disease or injury? .....

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19....

Where did injury occur? .....

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) Hank C. Wagner M. D.

(Address) 2027 Calvert.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

5919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 65919

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 7-14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 Abbott (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Archie Hatchett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 12 1885

8. AGE: Years	Months	Days	If less than one day
59 60	11	29	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Hatcher
13. Birthplace Va -

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Nancy English
(b) Address 908 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robert A. Ellis & Dgtr
(b) Address 1129 N. Caroline St.

19 (Date rec'd by registrar) FEB 16 1945 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1945, at 6:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury February 10 1945 10/2 M.
(b) Where did injury occur? Johnson & Lanvan, 1951 N. Gay St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Fell down stairs

23. Signature Howard J. Thelen M.D. Medical Examiner.
Date signed 2-13-45

VS 151

correct age is especially important. Physicians: please write the

G25920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G25920

Please write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 Rutland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie J. Summers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1899

8. AGE: Years 45 | Months 11 | Days 1 | If less than one day hr. min.

9. Birthplace S. Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Butler Howard
13. Birthplace S. C.

MOTHER
14. Maiden Name Phyllis M. Chestnut
15. Birthplace S. C.

16 (a) Informant Martha Summers
(b) Address 1112 Rutland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 16/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robert G. Elliott Dept.
(b) Address 1429 N. Caroline St.

FEB 16 1945

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1945, at 9:00 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D.
Medical Examiner.
Date signed 2/14/45

625921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 625921

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catonsville Aves.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Elkridge (If outside city or town limits write RURAL and give town)
(d) Street No. 1960 Railroad Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Ida E. Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife John B. Martin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31st 1882

8. AGE: Years	Months	Days	If less than one day
62	8	14	hr. min.

9. Birthplace Md. (Annapolis) (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Wm Hunter
13. Birthplace Annapolis Md.

MOTHER
14. Maiden Name Ellen (Unknown)
15. Birthplace Annapolis Md.

16 (a) Informant H. A. Burkhart
(b) Address 201 Taylor Ave - Hall Thorpe

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/45 (month) (day) (year)
(c) Cemetery ~~Loudon~~ Park
Location Balto. Md.

18 (a) Funeral director William Cox Inc
(b) Address 1217 St. Paul St.

FEB 16 1945 (Date received by Local Registrar)

(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-15 1945 at 11:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13 1945 to 2-15 1945. and that I last saw her alive on 2-15 1945.

Immediate cause of death	Duration
Acute Cardiac failure	
Due to Coronary Thrombosis & Myocardial Infarction	
Due to	
Other Conditions Pulmonary Edema	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas. E. Carroll Jr.

Address St Agnes Hosp Date signed 2/15/45 E. D.

X

625922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56B

Registered No. 625922

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: So. Balto Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 McKewin Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johansen, Marie E.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F.
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Oscar Johansen
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 10th 1896
8. AGE: Years 48 | Months 7 | Days 4 | If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business At Home

FATHER
12. Name John Deuerling
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Wutzler
15. Birthplace Balto. Md.

16 (a) Informant Oscar Johansen
(b) Address 617 McKewin Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (a) FEB 16 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14th 1945 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-4-1945 to 2-14 1945 and that I last saw h[illegible] alive on 2-14 1945.

Immediate cause of death: PULMONARY EMBOLISM — Duration

Due to

Due to

Other Conditions: MULTIPLE UTERINE Fibroids
(Include pregnancy within 3 months of death)

Date of operation 2-5-45

Major findings of operation: Multiple uterine fibroids

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul G. Lubato M. D.
Address 1213 Light St. Date signed 2-14-45

625923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

169

Registered No. 625923

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) ~~City~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2491 Fairway, Dundalk
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES VICTOR DOBSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	217-03-1330

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Leona B. Dodson
6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1917

8. AGE: Years	Months	Days	If less than one day
27	2	2	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Brakeman & Extra Conductor
11. Industry or business Penna. R.R.

FATHER
12. Name James Victor Dobson, Sr.
13. Birthplace Talbot Co., Md.

MOTHER
14. Maiden Name Estelle L. Kelly
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Leona P. Dobson
(b) Address 2941 Fairway, Dundalk, Md.

17 (a) Burial (b) Date thereof 2-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) Date received by Registrar FEB 16 1945 (b) Huntington Williams Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1945 at 10.30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to Partial evisceration of abdominal organs.

Other Conditions Avulsion of tissues.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-14-45 at 12/1 10.30 P. M.
(b) Where did injury occur? B&O R.R. - down North Ave. Bridge
(c) Did injury occur at home, on farm, industrial place, in public place? Public Indus. While at work? Yes
(d) Means of injury Crushed between two engines.

23. Signature Howard L. Wallace M.D.
Medical Examiner.
Date signed 2-15-45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 64

Registered No. 625924

Every item of information should be carefully supplied. Spaces must be filled CAREFULLY AND LEGIBLY. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp. 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Llewelyn Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Marie Dix

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19[illegible]

8. AGE: Years	Months	Days	If less than one day
	3		hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Raymond Dix
13. Birthplace Md.

MOTHER
14. Maiden Name Dorothy Maxwell
15. Birthplace Md.

16 (a) Informant Dorothy Dix
(b) Address 1616 Llewelyn Ave

17 (a) Burial (b) Date thereof 2-17-1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo S. Cook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (b)
(Date received by registrar) FEB 16 1945 Huntington for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1945, at 12 10 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status Thymicus — Lymphaticus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb. 15 1945

625925 BALTIMORE CITY HEALTH DEPARTMENT 625925

CERTIFICATE OF DEATH 307

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 310 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mack Pratt

3 (b) If veteran, name war —

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1901

8. AGE: Years	Months	Days	If less than one day
43 45	5		hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Co

FATHER
12. Name ?
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Maggie
15. Birthplace Calvert Co. Md.

16 (a) Informant Edward Pratt
(b) Address 562 Mosher St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. S. Kelson
(b) Address 1303 Pleasant St

19 (a) FEB 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14/45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 19 45 to 2/14/45 19 , and that I last saw h alive on 2/13/45 19 .

Immediate cause of death	Duration
heart failure	
aortic insufficiency	
Due to syphilis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature I. W. Mintz M. D.
Address Univ. Hosp. Date signed 2/16/45

VS 150

G25926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G25926

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St.
(c) Hospital or institution: University 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SADIE RANDALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county and state)

10. Usual Occupation Servant

11. Industry or business

FATHER
12. Name John Wesley Randall
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Davis
15. Birthplace Md.

16 (a) Informant Georgia Crayner
(b) Address 1729 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/45 (month) (day) (year)
(c) Cemetery or crematory Star
Location Anne Arundel Co. Md

18 (a) Funeral director Leo D. Nelson
(b) Address 1303 Preston St

B 2 16 1945 (Date received by registrar) Hattie Washington Williams (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1945, at 9.50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1945, to Feb 14 1945, and that I last saw her alive on February 1945.

Immediate cause of death	Duration
Toxemia & Staphylococcic Sepsis	
Due to Staphylococcus aureus non-hemolyticus	
Due to	
Other Conditions Diabetes mellitus arteriosclerosis, diabetic gangrene (Include pregnancy within 3 months of death)	

Date of operation Jan 19, 1945

Major findings of operation: diabetic gangrene left foot.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry W. Hollies, M.D.
Address University Hosp Date signed 2/15/45

VS t50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully specified. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 625927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3310 Elgin Ave.
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3310 Elgin Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LULA M. BRUCK

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Harry A. Bruck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1874

8. AGE: Years	Months	Days	If less than one day
70	2	13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel C. Mitchell
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Loubelle George
15. Birthplace Va.

16 (a) Informant Mr. Harry A. Bruck
(b) Address 3310 Elgin Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by Registrar) FEB 16 1945 (b) Huntington Williams, Registrar

VS 158

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15, 1945, at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to Feb 15 1945 and that I last saw h e alive on Feb 14 1945

Immediate cause of death	Duration
Coronary Occlusion	1 Day
Due to Hypertensive cardio vascular disease	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen F. Kellman M D M.D.
Address 6 E Biddle St Date signed 2/16/45

625928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832

625928 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4013 Liberty Heights Ave

(c) Hospital or institution: Alberta Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto.

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3335 Arondale Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Robert James King

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Carrie Arpt King

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1870

8. AGE: Years	Months	Days	If less than one day
74	10	28	hr. min.

9. Birthplace Somerset Co. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER

12. Name Sidney C. King

13. Birthplace Unknown

MOTHER

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Orville L. King

(b) Address 3335 Arondale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-45 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cemetery

Location Baltimore, Md.

18 (a) Funeral director Loring Byers.

(b) Address 5005 Park Heights Ave.

19 (a) FEB 16 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1945, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Feb 14 1945 and that I last saw him alive on Feb 14 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Atherosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Alan D Bubert M. D.

Address 4803 Park Heights Ave Date signed 2/16/45

VS 150

G25929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G25929 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1403 Myrtle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 Myrtle Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James R. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 1889

8. AGE: Years 55 | Months 9 | Days 14 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Oscar Johnson
13. Birthplace Va.

MOTHER 14. Maiden Name Mary Edmonds
15. Birthplace Va.

16 (a) Informant Frances Johnson
(b) Address 1403 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) FEB 16 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15, 1945, at 5:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14 1945, to 2/15 1945 and that I last saw h[illegible] alive on 2/15/45.

Immediate cause of death — Duration

Due to Acute Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams M. D.

Address 1131 Eutaw Pl. Date signed 2-16-45

G25930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 12

G25930 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 640 W. Mulberry St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 640 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Bertha Anderson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Anderson Anderson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18th 1880

8. AGE: Years 64 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Goldsboro N. C
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William Williams
13. Birthplace N. C

MOTHER 14. Maiden Name Rena V.
15. Birthplace N. C.

16 (a) Informant Ulysses Bryant
(b) Address 600 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Bryson & Mamie H. Knight
(b) Address 721 Aliceanna St

19 (a) Date received FEB 16 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1945, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1944 to Feb 13 1945 and that I last saw h[illegible] alive on Feb 13 1945

Immediate cause of death: Hypertension Cardio-Renal Vascular — Duration 6 mo

Due to — Duration

Due to — Duration

Other Conditions — Duration 7 Days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. N. Haskins

Address 1115 Pulaski Date signed 2/15/45 D

25931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 25931

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 N. Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 26yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 N. Bond (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Addie Rowland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race b

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John E. Rowland

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Dec. 5th 1891

8. AGE: Years 53 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Powhatan Co. Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Willis Crider
13. Birthplace Va.

MOTHER
14. Maiden Name Georgina L.
15. Birthplace Va

16 (a) Informant John E. Rowland
(b) Address 604 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. A. Co. Md.

18 (a) Funeral director Bryant Wrapp & Knight
(b) Address 721 Russell St

19. (a) Date (Month, day, year) FEB 16 1945 (b) Registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12-45 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1944 to 2-12 1945 and that I last saw her alive on 2-12 1945

Immediate cause of death: Bronchopneumonia — Duration 6 wks

Due to: Arthritis & Bursitis — Duration 4 yrs.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Blake M.D.

Address 1307 N. Charles St. Balto. Date signed 2/15/45

625932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47C

625932 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Beale court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 Beale court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Booze Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Norris Booze

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) 5-12-1901

8. AGE: Years 43 | Months 9 | Days - | If less than one day ... hr. ... min.

9. Birthplace Balto, Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Joseph Booze

13. Birthplace A. A. co. Md

MOTHER 14. Maiden Name Georgeanna Hill

15. Birthplace Miss.

16 (a) Informant Susie Byrd

(b) Address 610 E. 28th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-1945 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. A. co. Md

18 (a) Funeral director Belsont Francis W. Wright

(b) Address 720 Edmondson St

19 (a) FEB 16 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1945; at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9th 1945 to Feb 11th 1945, and that I last saw him alive on Feb 9th 1945

Immediate cause of death Pericle Bronchogenic carcinoma — Duration

Due to

Due to

Other Conditions. Emaciation.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harris A. Sinks M. D.

Address 11 S. Arlington Ave Date signed 2/16/45

VS 150

Dr Rosen
2413 E. Monument St

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 625933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1304 N. Kenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 N. Kenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Swanke

3 (b) If veteran, name war —
3 (c) Social Security Account No. 217-01-6982

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Deana Swanke
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) March 26-1880

8. AGE: Years	Months	Days	If less than one day
64	10	18	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Engineer - Frankfort
11. Industry or business Distillery

FATHER
12. Name Wm Swanke
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Deana Swanke
(b) Address 1304 N. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 16-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Md

18 (a) Funeral director ~~Edward~~ Mame C. Syfer
(b) Address 1600 W. North Ave

19 FEB 16 1945 (Date received by registrar) Funeral for Williamsport Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1945, at 11P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Feb 13 1945; and that I last saw him alive on Feb. 11 1945.

Immediate cause of death: Acute Cardiac Failure — Duration 1/2 hour

Due to Arteriosclerotic Heart + Kidney Disease — 2 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M.D. M. D.
Address 2413 E Monument St Date signed 2/16/45

VS 180

625934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

625934

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Rd
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-4-6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 400 S. Belnord Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Henry D. Leim

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9 1872

8. AGE: Years	Months	Days	If less than one day
72	10	2	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER
12. Name Henry A Leim
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Anne E Wright
15. Birthplace Dorchester Co Maryland

16 (a) Informant Mount Hope Retreat
(b) Address Baltimore – 15 Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 13-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director E Haworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) FEB 16 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1945, at 8:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1934, to Feb 11 1945, and that I last saw him alive on Feb 11 1945

Immediate cause of death	Duration
Coronary Thrombosis	10 days
Due to	
Due to	
Other Conditions Arteriosclerosis Melanoderma	16 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Duncan P. Aloya M. D.
Address 3 W Preston St Date signed

625935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

625935 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17 h. Bradford St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL, and give town)
(d) Street No. 17 h. Bradford st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maria C. Varacalle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Saverio Varacalle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6, 1884

8. AGE: Years	Months	Days	If less than one day
61	1	8	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Mario Tessi
13. Birthplace Italy

MOTHER
14. Maiden Name Stella
15. Birthplace Italy

16 (a) Informant Husband Saverio Varacalle
(b) Address 17 h. Bradford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17- 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank V. Sipitone
(b) Address 2518 E. Baltimore St

19 FEB 16 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14th 1945, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20th 1944, to Jan 1st 1945, and that I last saw h~~e~~ alive on Jan 1st 1945.

Immediate cause of death	Duration
Carcinoma of the stomach	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Jenkins M. D.
Address 100 n. Milton Ave Date signed 2/15/45

X

625936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

625936
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1 wk
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4249 Nicholas Avenue
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Anna Pitt

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Fred W. Pitt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1857

8. AGE: Years	Months	Days	If less than one day
87	6	14	hr. min.

9. Birthplace Glouster Virginia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Virginia

MOTHER
14. Maiden Name Anna Thrift
15. Birthplace Virginia

16 (a) Informant Mr. Arthur Pitt
(b) Address 4249 Nicholas Avenue

17 (a) Burial (b) Date thereof 2-17-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Frederick Rd. Baltimore Md

18 (a) Funeral director Albert L. Hilleary
(b) Address 1606 E. Chester Street

19 (a) FEB 16 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14 1945 at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/11 1945 to 2/14 1945, and that I last saw h[illegible] alive on 2/13 1945.

Immediate cause of death: Pneumonia
Contributing
Due to
Due to
Other Conditions: Arthritis
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration: 5 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 2904 Garrison Blvd Date signed 2/15/45

YS 3

MANTEGNA

625937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. 625937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address ~~[illegible]~~ Modisco, Linden ~~[illegible]~~ #13

(c) Hospital or institution: Maryland General Hospital 8

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore 5

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1838 N Castle St. #13

(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Carl Mantegna

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W,	M,

6 (b) Name of husband or wife Josephine Mantegna

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 29 1892

8. AGE: Years	Months	Days	If less than one day
52	2	17	..... hr. ..... min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Ice Dealer

11. Industry or business " "

FATHER

12. Name Singer Mantegna

13. Birthplace Italy

MOTHER

14. Maiden Name Pauline Castelli

15. Birthplace Italy

16 (a) Informant Josephine Mantegna

(b) Address 1838 N. Castle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Back

18 (a) Funeral director Paul Vigliato Inc

(b) Address 1546 N. Gay St

19 (a) ..... (b) .....

Registrar

FEB 16 1945

VS Form

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1945, at 2:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1945, to Feb. 15 1945, and that I last saw h[illegible] alive on Feb. 15 1945.

Immediate cause of death Paralytic ileus ~~[illegible]~~

Due to Strangulated Obstruction 5 day after appendectomy

Due to .....

Other Conditions Broncho pneumonia

(Include pregnancy within 3 months of death)

Date of operation Feb. 10, 1945

Major findings of operation: acute appendicitis

of autopsy: .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature [illegible] M. D.

Address Md. Gen. Hosp. Date signed 2/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

625938 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4316 Groveland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4316 Groveland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo T. Kelly, Sr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Annie Elizabeth Kelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jany 14/1881

8. AGE: Years 64 | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Lieut Police Dept retired

11. Industry or business

FATHER
12. Name John Kelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Strohmeyer
15. Birthplace Chambersburg Pa

16 (a) Informant Leo T. Kelly Jr.
(b) Address 3117 Belvedere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 19/1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Harry A. Arnold
(b) Address 4204 Edgewood Ave

19 (a) (Date rec'd by registrar) (b) Registrar

vs 1st FEB 16 1945 Huntington Hillsboro, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1945 at 5.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1936 to Feb 15 1945 and that I last saw h[illegible] alive on Feb 15 1945

Immediate cause of death	Duration
Coronary Thrombosis	Months
Due to Arterio Sclerosis	10 yrs
Due to Chronic Myocarditis	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? /
(e) Means of injury

23. Signature Ralph A Zierler M. D.
Address 231 E Eutaw Pl Date signed 2/16/45

X

625939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

✓ 625939 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md
(c) Hospital or institution: Church Home & Infirmary 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State M (b) County
(c) City or town BALTO 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3428 E Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BLAKE, MR. CHARLES

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mrs. Margaret Blake
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1[illegible]-187[illegible]

8. AGE: Years	Months	Days	If less than one day
68	1	1	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Sexton
11. Industry or business

FATHER
12. Name Charles Blake
13. Birthplace /

MOTHER
14. Maiden Name Alice Bennett
15. Birthplace Virginia

16 (a) Informant Mrs Margaret Blake
(b) Address 3428 E Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-45 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location South Dyer

18 (a) Funeral director John E Miller Inc
(b) Address 2405 E Oliver St

19 (a) (Date rec'd by registrar) FEB 16 1945 (b) Huntington Williams, M.D. (Address)

VS Ed.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14 1945, at 11 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11-1945, to 2-12-1945, and that I last saw him alive on 2-14 1945.

Immediate cause of death	Duration
Hemiplegia	12 hrs
Peritonitis	
Due to Perforation of colon	12 hrs
Due to	
Other Conditions Pelvic abscess & adhesion (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation: See above	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marvin V. Davis
Address Church Home Date signed 2-15-45 M.D.

625940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

625940 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1403 N. Eutaw Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 N. Eutaw Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Lee Curtain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Maude Curtain

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) April 2 1868

8. AGE: Years	Months	Days	If less than one day
76	10	12	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Samuel Curtain
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Julia Stout
15. Birthplace Balto. Md.

16 (a) Informant Maude Curtain
(b) Address 1403 N. Eutaw Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location North Ave.

18 (a) Funeral director John C. Miller Jr
(b) Address 2425 E. Oliver St

19 (a) (Date rec'd by local Reg.) FEB 18 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1945, at 3:1 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1945 to Feb 14 1945, and that I last saw h[illegible] alive on Feb 13 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 6 days

Due to

Due to Arter. Sclerosis — 5 yrs
Hypertension Heart Dis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address 1500 E. 33rd St. M. D. Date signed 2/15/45

Huntington Pittsburgh, Pa.

X

625941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

625941

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1340 Eldon Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1340 Eldon Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grover Cleveland White

3 (b) If veteran, name war: 1st World
3 (c) Social Security Account No. 216-22-4700

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elma Elizabeth White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14-1888

8. AGE: Years 56 | Months 10 | Days — | If less than one day: hr. min.

9. Birthplace Middlesex Co. Virginia (Town, county, and state)
10. Usual Occupation Police
11. Industry or business Retired 1 Year

FATHER
12. Name Herbert White
13. Birthplace Virginia

MOTHER
14. Maiden Name Georgia Sibley
15. Birthplace Virginia

16 (a) Informant Mrs. Elma E. White
(b) Address 1340 Eldon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 17-1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (b) Date received by Local Registrar FEB 16 1945 Signature of Local Registrar Wilmer M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1945, at 2:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1/45 19 , to 2/14/45 19 , and that I last saw him alive on 2/14/45 19 .

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerotic (VHD)	
Due to	
Other Conditions Angina Pectoris	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Willard Applefeld
Address 2511 Reisterstown Rd Date signed 2/15/45

Willard Applefeld

VS 150

625942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1572

Registered No. 625942

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Sterling Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Madison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1945

8. AGE: Years	Months	Days	If less than one day
			12 hr. 20 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Rozie Jones
13. Birthplace Georgia

MOTHER
14. Maiden Name Estelle Douglas
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 16 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 16 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

2524

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 1945 at 5:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1945, to Feb. 2 1945, and that I last saw her alive on Feb. 2 1945.

Immediate cause of death	Encephalocele	Duration
Due to		
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. L. Griffith M. D.
Address Johns Hopkins Hospital Date signed 2-6-45

X

625943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1659

625943 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9/9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 N. Central Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Thornton #2

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-12-45

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name unk
13. Birthplace unk

MOTHER
14. Maiden Name Ruth Thornton
15. Birthplace unk

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 16 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 16 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1945 at 8:11 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1945 to Feb 13 1945, and that I last saw her alive on Feb 13 1945.

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John R. Brennaman M. D.
Address JHH Date signed 2-14

VS 150

2523

625944

468368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

625944 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 N. Central Ave. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Girl Thorton #1 or Thornton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 2-12-45

8. AGE: Years	Months	Days	If less than one day
		2	..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name 2 2 Unk
13. Birthplace Unk

MOTHER
14. Maiden Name Ruth Thorton.
15. Birthplace Unk

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a)..... (Burial, cremation, or removal) (b) Date thereof..... (month) (day) (year)
(c) Cemetery or crematory.....
Location JOHN HOPKINS MEDICAL SCHOOL FEB 16 1945

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 (a) FEB 16 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Feb-14 1945, at 1.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1945 to Feb 14 1945 and that I last saw h.. alive on Feb. 14 19 45

Immediate cause of death	Duration
1 Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature John R. Birmingham M. D.
Address JHH Date signed Feb 14

VS 150

2529

X

625945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625945
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore, Dundalk, 22
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7407 School Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1899

8. AGE: Years	Months	Days	If less than one day
45	8	16	hr. min.

9. Birthplace Frostburg, Maryland (Town, county, and state)
10. Usual Occupation Supervisor
11. Industry or business Eastern Aircraft

FATHER
12. Name Llewellyn
13. Birthplace Frostburg, Maryland

MOTHER
14. Maiden Name Sharp
15. Birthplace Frostburg Maryland

16 (a) Informant Hospital Records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Allegheny Cemt.
Location Frostburg Md.

18 (a) Funeral director Maurice J. Hoffman
(b) Address 1639 N Broadway

19 (a) 2 16 1945 (Date rec'd by registrar) (b) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1945, at 3 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4 1945 to Feb. 16 1945, and that I last saw him alive on Feb. 15 1945

Immediate cause of death Respiratory Failure — Duration

Due to Dissecting aneurism of Thoracic and abdominal aorta

Due to

Other Conditions Bilateral hemothorax
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Millard T. Trabold, D
Address University Hospital Date signed 2/16/45

VS 150

625946

YA-91831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625946 ✓ 942 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS 8 W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 N. Montford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Reilly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 9, 1878

8. AGE: Years 66 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Bernard Reilly (d)
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Gannon (d)
15. Birthplace Ireland

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB-19-1945 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director J. Evans Son Inc
(b) Address 118 W. Mt. Royal ave.

19 (a) Filed by registrar (b) Registrar

FEB 16 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15, 1945 at 8:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27, 1945 to Feb. 15, 1945, and that I last saw h or alive on Feb. 15, 1945.

Immediate cause of death pulmonary edema — Duration ?

Due to myocardial infarction

Due to coronary occlusion

Other Conditions multiple cerebral accidents (thrombosis); gen. arteriosclerosis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. W. Perry Jr. M. D.

Address City Hosp. Date signed 2-15-45

625947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 81a

625947 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Shields Place (If rural give location)
(e) Citizen of foreign country? Md. (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Alston

3 (b) If veteran, name war

3 (c) Social Security Account No. 241-149-354

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jennie B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1891

8. AGE: Years: 53 | Months: 6 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Littleton, N.C. (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER 12. Name: John Alston
13. Birthplace: North Carolina

MOTHER 14. Maiden Name: Susan Knight
15. Birthplace: North Carolina

16 (a) Informant: Jennie B. Alston
(b) Address: 1206 Shields Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 17 1945 (Month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location: Baltimore Co. Md.

18 (a) Funeral director: Mrs. Lenzy A. Hallen
(b) Address: 1631 Druid Hill Ave.

19 (a) FEB 16 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14, 1945, at 5:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 1945, to 2/14 1945, and that I last saw him alive on 2/14 1945.

Immediate cause of death: Pneumococcal meningitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature V. R. Corry M.D.
Address Provident Hospital Date signed 2/16/45

X

G25948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 942

G25948 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2126 Division St Dist.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2126 Division St
(Rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Wade

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1893

8. AGE: Years 51 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Ignatius Wade
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna Thompson
15. Birthplace Baltimore, Md.

16 (a) Informant Sevilla Wade
(b) Address 2126 Division St.

17 (a) Burial (b) Date thereof Feb. 17 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Wm. Chas. H. Hailman
(b) Address 1631 Druid Hill Ave.

19 (a) FEB 6 1945 (b) Huntington Williams M.D.
Date received by Registrar Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 1945, at 10 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature C. J. Sobieski M.D.
Medical Examiner.
Date signed 2/17/45

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PENCIL, WITH UNFADING INK.

625949 625949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1710

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT NAME, WRITE UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No 1605 N. Durham St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Diegelmann

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	W.

6 (b) Name of husband or wife Justina Diegelmann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27-1868

8. AGE: Years	Months	Days	If less than one day
76	3 4	13 18	hr. min.

9. Birthplace Washington D.C.
(Town, county and state)

10. Usual Occupation
11. Industry or business —

FATHER
12. Name Henry Diegelmann
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Joseph J. Diegelmann
(b) Address 1605 N. Durham St.

17 (a) Burial (b) Date thereof 2-17-1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Flynn & Flynn
(b) Address 1476 Light St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14-1945; at 8 25 A.M.

21. I certify that I took charge of the remains described above, held an Inspection + Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Fractured ribs, bruised lungs + contusions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-12-45 at 9.53 P. M. 8/5
(b) Where did injury occur? North Ave + Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by Street car

23. Signature Howard J. Waldeck M.D.
Medical Examiner.
Date signed 2-14-45

625950 BALTIMORE CITY HEALTH DEPARTMENT 625950
CERTIFICATE OF DEATH
F3D Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison
(c) Hospital or institution Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 DA
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3314 Liberty Heights Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LEON MARMOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lillie nee Rhachmist

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation ? Pharmacist

11. Industry or business ?

FATHER
12. Name ? Jacob Laird -
13. Birthplace Russia

MOTHER
14. Maiden Name Frances -
15. Birthplace Russia

16 (a) Informant Lillie Marmor (Wife)
(b) Address 3314 Liberty Hgts. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-45 (month) (day) (year)

(c) Cemetery or crematory Balto. Hebrew
Location

18 (a) Funeral director Jage Levine Inc
(b) Address 1439 E. Balto. St

19 (a) FEB 16 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15, 1945, at 11 P.M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner.
Date signed 2/16/45

VS 151

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH UNFADING INK.

G25951 ✓ G25951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT St. & RUTLAND AVE
(c) Hospital or institution: SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 3 MONTHS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2128 Mt. ROYAL TERRACE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. LENA Berkowitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Emma Bernstein

13. Birthplace Russia

14. Maiden Name Bazeh

15. Birthplace Russia

16 (a) Informant Mr. Berger

(b) Address 2128 Mt. Royal Terrace

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-17-45 (month) (day) (year)

(c) Cemetery or crematory New York City, N.Y.

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Balto. St

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 16 1945

VS 160

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16 1945, at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13 1945, to 2-16 1945, and that I last saw her alive on 2-16 1945.

Immediate cause of death: Respiratory failure — Duration

Due to Intracranial hemorrhage

Due to Hypertensive + Arterio sclerotic C-Vascular

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jerome A. Durland M. D.

Address Sinai Hospital Date signed 2-16-45

625952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. 625952

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 Somerset Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 Somerset Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Davis Parlange

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 21 May 1854

8. AGE: Years 89 | Months 8 | Days 25 | If less than one day hr. min.

9. Birthplace New Orleans, Louisiana (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Arthur Davis
13. Birthplace New Orleans, Louisiana

MOTHER
14. Maiden Name Louise Antoinette Déquir
15. Birthplace New Orleans, Louisiana

16 (a) Informant Mrs. Franklin G. Allen
(b) Address 610 Somerset Road, Baltimore

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Feb 17 1946 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Avenue Baltimore

18 (a) Funeral director H. W. Jenkins
(b) Address Orchard Street, Baltimore

FEB 17 1946 Huntington Williams Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Feb 1946, at 3.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1935 to 15 Feb 1946, and that I last saw him alive on 15 Feb 1946.

Immediate cause of death Senility. — Duration

Due to Arterio-sclerosis

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury None

23. Signature Corbus Sorrell, M.D.

Address 717 Park Ave Date signed 16 Feb 1946

VS 150

X

G25953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G25953 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. CAUTION: Before writing, read carefully the instructions printed on the back. Every question must be answered, or the certificate will be returned for amending. Do not write in the space reserved for registration data. Do not write in the space reserved for registration data. Do not write in the space reserved for registration data

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 625954

625954

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lake Drive & Linden Ave. Riviera Apts.

(c) Hospital or institution:

13-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City ~~or town~~ - Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Riviera Apts. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME TILLIE MAY WURTZBURGER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~or wife~~ Joseph Wurtzburger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1871

8. AGE: Years 73 | Months 10 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name William May,

13. Birthplace Germany.

MOTHER

14. Maiden Name Amalie Straus,

15. Birthplace Germany.

16 (a) Informant Mr. Alan Wurtzburger,

(b) Address Pikesville, Md.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 2/18/45. (month) (day) (year)

(c) Cemetery or ~~crematory~~ - Baltimore Hebrew

Location Balto. Md.

18 (a) Funeral director David Sonneborn & Son

(b) Address 1902 Eutaw Place.

(c) FEB 17 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16th. 1945. at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1942 to Jan 29 1945, and that I last saw h-- alive on Feb 15 1945.

	Duration
Immediate cause of death: Respiration failure	1 day
Due to: Cerebral Hemorrhage - Jime	2.4 2 2½ years
Due to:	
Other Conditions: Arteio-sclerosis (Include pregnancy within 3 months of death)	3 yrs

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature I Frederick Lodtz M.D.

Address Temple Garden Apts X Date signed 2/16/45

625955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

625955

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Baptist Sanitarium
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 737 N. Hamburg St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice M. Pentz

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frederick L. Pentz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9 1892

8. AGE: Years 52 | Months 5 3 | Days 7 | 8 6 | If less than one day hr. min.

9. Birthplace Berlin, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Wm Hennigan
13. Birthplace Md

MOTHER
14. Maiden Name Emma Schafer
15. Birthplace Washington D.C.

16 (a) Informant Frederick L. Pentz
(b) Address 737 N. Hamburg St

17 (a) BURIAL (b) Date thereof 2/17/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director F. O. Whitelock Son
(b) Address 700 Eutaw Place

19 (a) Huntington Williams M.D.
(Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-15- 1945 at 9-15 a. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock

Due to 2nd - 3rd degree burns

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 21/1

(a) Date of injury 2-14-45 at 9.45 a. M.

(b) Where did injury occur? 737 N. Hamburg Street

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Explosion of oil stove

23. Signature Howard J. Williams M.D.
Medical Examiner.

Date signed 2-15-45

PRINT OR WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and entered. Physicians: please write the causes of death clearly and legibly. Every item correct age is especially important.

625956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

625956

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution:
Lombard & Greene Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 31 Prospect Pl Catonsville
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Bolton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife TAGMADGE-BOLTON

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR 22 1888

8. AGE: Years 56 Months 8 Days 25 If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Martin Morgenweck
13. Birthplace Germany

MOTHER
14. Maiden Name Adelaide Schleipe
15. Birthplace Germany

16 (a) Informant Hospital Records
(b) Address LOMBARD-&-GREENE-STS

17 (a) BURIAL (b) Date thereof 2/19/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory LOUDON-PARK
Location Baltimore, Md.

18 (a) Funeral director F. J. Wappert Son
(b) Address 150 W. Baltimore St.

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150 FEB 17 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/16 1945, at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1945, to 2/16 1945, and that I last saw her alive on 2/16 1945.

Immediate cause of death	Duration
Respiratory failure	4 hrs.
Due to Cardiac failure	
Due to Cardio renal vascular disease	15 yrs.
Other Conditions Obesity	10 yrs.

(Include pregnancy within 3 months of death)

Date of operation 2/15

Major findings of operation: Incarcerated multilocular umbilical hernia

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Kemp M. D.

Address Kennedy Bldg. Date signed 2/16/45

625957

625957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6415 Reisterstown Rd.
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos. 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Delaware (b) County
(c) City or town Wilmington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 Bancroft Parkway
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME (Sister) Claude Agnes Mudd

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1877

8. AGE: Years	Months	Days	If less than one day
67	10	6	hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual Occupation Religious (Sister)
11. Industry or business

FATHER
12. Name Alonzius Mudd
13. Birthplace Washington, D. C.

MOTHER
14. Maiden Name Mary Barbour
15. Birthplace Washington, D. C.

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reistertown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-45 (month) (day) (year)
(c) Cemetery or crematory Visitation
Location Wilmington Del.

18 (a) Funeral director Sodowski Funeral Co.
(b) Address 1050 Madison Ave.

19 (a) FEB 17 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1945, at 1:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1944 to Feb 16 1945, and that I last saw h[illegible] alive on Feb. 16 1945.

Immediate cause of death	Duration
Cardio Vascular Collapse	10 hr.
Due to	
Due to	
Other Conditions Manic Depressive psychosis	9 Mths

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Herman C. Glazier M. D.
Address 336 Medical Arts Bldg. Date signed

VS 8

Huntington Williams M.D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

665958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

Registered No. 665958

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 27-132
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6002 Prescott Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1. 1867

8. AGE: Years	Months	Days	If less than one day
78 73	1	13	hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name James Edwards Sr
13. Birthplace Va.

MOTHER
14. Maiden Name not known
15. Birthplace Va.

16 (a) Informant Mrs J. Edward Ford
(b) Address 6002 Prescott ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/45 (month) (day) (year)
(c) Cemetery or crematory Mt. calvard
Location Annelsyndel Co. Md.

18 (a) Funeral director Wm. J. Chatman Jr
(b) Address 6049 Prescott ave.

19 (a) FEB 17 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1945 at 7 20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary Edema ; Contusions of Abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury Feb 6 at 1945 18/2 80 8 P.M.
(b) Where did injury occur? Carrolton Ave & Fayette St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury pedestrian struck by Auto car

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb 15 1945.

625959 Shawver 625959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hosp. for Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 16 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 245 S Maryland Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Shawver

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/15/45

8. AGE: Years	Months	Days	If less than one day
—	—	—	16 hr. 2 min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Cecil Carl Shawver
13. Birthplace Glenvale, W. Va.

MOTHER
14. Maiden Name Christine Thomas Joyner
15. Birthplace Lewisburg, W. Va.

16 (a) Informant Cecil Carl Shawver
(b) Address 245 S Maryland Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL FEB 17 1945

18 (a) Funeral director Commissioner of Health
(b) Address
FEB 17 1945 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/16/1945, at 7 25 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1945, to 2/16 1945 and that I last saw him alive on 2/16 1945

Immediate cause of death Intracranial Hemorrhage — Duration 16 hrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elizabeth Acton, M.D.
Address Hosp. for Women of Md. Date signed M. 3/10/45 D.

VS 8

2526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. 645960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2122 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2122 Mt. Holly St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: ELLEN JANE WALLER

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Richard Waller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 28, 1860

8. AGE: Years	Months	Days	If less than one day
84	3	18	hr. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: George Rider
13. Birthplace: Md.

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Miss Ruth Waller
(b) Address: 2122 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/45 (month) (day) (year)
(c) Cemetery or crematory: Taylor Cem.
Location: Sharptown, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

(a) Date received: FEB 17 1945 (b) Registrar: Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 16, 1945, at 1.35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1940 to Feb 16 1945, and that I last saw her alive on Feb. 16 1945.

Immediate cause of death	Duration
Arteriosclerosis	10 Yr.
Due to Chronic Myocarditis	5 Yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H. H. Cloaden M. D.
Address 2252 W Mor Date signed 2/17/45

VS 150

625961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 330

625961 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2301 Maisel St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2301 Maisel St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Adolph Seebold

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
71	3		hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired Plumber
11. Industry or business

FATHER
12. Name Gotlieb Seebold
13. Birthplace Germany

MOTHER
14. Maiden Name Caffeni
15. Birthplace Germany

16 (a) Informant Amelia
(b) Address 2301 Maisel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/45 (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location Edmondson ave

18 (a) Funeral director Edward Towles
(b) Address

19 (a) FEB 17 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1945, at 5 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1945, to Feb 16 1945, and that I last saw him alive on Feb 15 1945.

Immediate cause of death	Duration
(a) Acute Dilatation of Heart	2 days
Due to Lobar pneumonia	8 days
Due to Grippe	8 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. V. Glenn
Address 9708 Harford Jerry Md Date signed 2/16/45 M. D.

VS 150

625962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625962 Registered No. 309

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carlin Ell St.
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 E. Eager St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William anthony Barrett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/11/1915

8. AGE: Years 30 Months 1 Days 5 If less than one day hr. min.

9. Birthplace Mt Savage. Md (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Railroad Surfacer

FATHER 12. Name Anthony Barrett.

13. Birthplace Mt Savage, Md

MOTHER 14. Maiden Name Ida Shipley

15. Birthplace Mt Savage, Md

16 (a) Informant Miss. Emeline Barrett

(b) Address 1117 E Capitol St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/45 (month) (day) (year)

(c) Cemetery or crematory Washington Co.

Location

18 (a) Funeral director J. J. Doherty Son

(b) Address 131 Eight Ave

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 17 1945 Hunting for Hillcrest, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16 1945, at 9:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3 1945 to 2-16 1945 and that I last saw h~~im~~ alive on 2-16 1945.

Immediate cause of death: Lobar Pneumonia

Due to: Myocardial Failure

Due to: Suppurative pericarditis

Other Conditions: Syphilis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of ~~operation~~ autopsy: Bilateral Lobar pneumonia, suppurative pericarditis

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at A M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. E. Robertson M. D.

Address St Josephs Hospital Date signed 2-16-45

108

625963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V45F

Registered No. 625963

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital 2659
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 729 S. Grundy St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Leopold FLATCHER

3 (b) If veteran, name war: NO
(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Antonia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/25/1889

8. AGE: Years	Months	Days	If less than one day
55	8	22	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Baker
11. Industry or business ST. AGNES HOSP.

FATHER
12. Name LEOPOLD FLATCHER
13. Birthplace AUSTRIA

MOTHER
14. Maiden Name MARIE TIEFENBACHER
15. Birthplace AUSTRIA

16 (a) Informant ANTONIA FLATCHER (WIFE)
(b) Address 729 S. GRUNDY ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 19/45 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Libby & Zeller Co.
(b) Address 401-403 WOLFE ST.

19 (a) FEB 17 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/16 1945, at 7:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/30 1944 to 2/16 1945 and that I last saw him alive on 2/16 1945.

Immediate cause of death: Sudden death (cause unknown)

Due to: Carcinoma of the tonsil c metastasis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jose A Calvary de Chondeun M. D.
Address St agnes Hosp Date signed 2-16-45

VS 150

625964

Worth

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

625964

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto —
(c) City or town Govanda le
(If outside city or town limits, write RURAL and give town)
(d) Street No. 302 Central Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Wortle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-6-62

8. AGE: Years	Months	Days	If less than one day
82	10	10	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Gardener

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Nicols
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 10 45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Lot 2 Sec 2 Rd 8 Lot

18 (a) Funeral director Chas. E. Roberts & Sons
(b) Address 403 S. Wolfe St.

19 FEB 17 1945 (Date rec'd by registrar) Hunterstown Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16 1945, at 11 A 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 1945 to 2-16 1945 and that I last saw h alive on 2-16-1945

Immediate cause of death Uremia — Duration

Due to Acute pyelonephritis

Due to Uncontrolled diabetes

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Acute pyelonephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus M.D.
Address Johns Hopkins Hosp. Date signed 2/16/45

VS 150

625965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1106 C

Registered No. 625965

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 238 Silver Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 238 Silver Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Turner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Mal | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rosie Turner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/1/05

8. AGE: Years 39 | Months 4 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business

FATHER
12. Name James Turner
13. Birthplace S.C.

MOTHER
14. Maiden Name Sarah ?
15. Birthplace

16 (a) Informant Rosie Turner.
(b) Address 238 Silver Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Eloy O. Wilson

18 (a) Funeral director
(b) Address 1000 Brantley Ave

FEB 17 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14-45 19 , at 11 37 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-10-45 19 , to 2-14-45 19 , and that I last saw him alive on 2-13-45 19

Immediate cause of death	Duration
Acute Dilitation of the Heart	Sudden
Due to Bronchitis	3 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Marion Adams
Address 312 E 23rd St Date signed 2-17-45 M. D.

VS 150

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 6[illegible]5966

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 425 N. Pine St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 425 N. Pine St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Queen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 27 1882

8. AGE: Years	Months	Days	If less than one day
~~97~~ 62	11	17	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Pinnell Queen

13. Birthplace Md

MOTHER 14. Maiden Name Isabella Collins

15. Birthplace Md

16 (a) Informant Miss Mary Queen

(b) Address 1113 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-45 (month) (day) (year)

(c) Cemetery or crematory [illegible]t Auburn [illegible]

Location Baltimore [illegible]

18 (a) Funeral director [illegible] Agnes A. Kennedy

(b) Address 578 N. Biddle St

FEB 17 1945 (Date rec'd by Registrar) (b) [illegible] Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14 1945, at 9:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C-V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.

Date signed 2-14-45

(over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M-28136?

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625967

131a

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 103 N. Decker St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Liebkey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	?

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1895

8. AGE: Years	Months	Days	If less than one day
49	8	5	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER

12. Name Harry Liebkey

13. Birthplace Md.

MOTHER

14. Maiden Name Mary Flynn

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14-45 (month, day) (year)

(c) Cemetery or crematory Mem. Cem.

Location Old Frederick Rd.

18 (a) Funeral director John A. Heflin

(b) Address 5002 E. Baltimore St.

19 (a) (Date received by registrar) FEB 17 1945 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1945, at 9.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1945, to Feb. 15 1945, and that I last saw him alive on Feb. 15 1945.

	Duration
Immediate cause of death cerebral hemorrhage	24 h.
Due to hypertensive cardiovascular disease	
Due to arteriolar nephrosclerosis	
Other Conditions gen. arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature C. A. Perry J. M. D.

Address City Hosp. Date signed 2-16-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G25968 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1734 Lamont Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1734 Lamont Avenue (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John Harry Gisreil

3 (b) If veteran, name war	3 (c) Social Security Account No.
1st World War	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nettie Z. Gisreil
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-7-1881

8. AGE: Years	Months	Days	If less than one day
63	3	8	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name George Z. Gisreil
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Sarah Lewis
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Nettie Z. Gisreil
(b) Address 1734 Lamont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Ave Balto. Md

18 (a) Funeral director Albert L. Kilby Jr.
(b) Address 1606 N. Chester St

19 (a) Filed 2-17-1945 (b) (Date rec'd by Registrar) Livingston Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1945, at 2-30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1945, to Feb 15 1945, and that I last saw him alive on Feb 15 1945.

Immediate cause of death	Duration
Edema Lungs	1 day.
Due to Chronic Myocarditis	3 years
Due to Arterio-Sclerosis	8 year
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed Feb 16-45

625969

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170 C

625969

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BALTIMORE MD.
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 6226 ELLIOTT STREET (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HERBERT F. DEHART

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 26, 1909

8. AGE: Years	Months	Days	If less than one day
35	9	21 20	hr. min.

9. Birthplace WOOLVINE, VA. (Town, county, and state)

10. Usual Occupation ELECTRICIAN

11. Industry or business SHIPYARD

FATHER
12. Name MORGAN DEHART
13. Birthplace WOODWINE

MOTHER
14. Maiden Name ANNIE BRANNAN
15. Birthplace WOODWINE, VA.

16 (a) Informant MRS. MARY M. DEHART
(b) Address 6226 ELLIOTT STREET

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 2/18/45 (month) (day) (year)
(c) Cemetery or crematory Bluefield
Location BLUEFIELD, W. VA.

18 (a) Funeral director ALBERT L. HILTZ, SR.
(b) Address 1616 N. CHESTER STREET

19 (a) FEB 17 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 16 1945, at 3:25 P. M

21. I certify that I took charge of the remains described above, held an INSPECTION & INQUIRY Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions Fractured jaw, laceration, contusion brain & bruises.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-14-45 at 5:45 P. M. 26/5
(b) Where did injury occur? BUSHEY ST. & DUNDALK AVE.
(c) Did injury occur at home, on farm, industrial place, in public place? PUBLIC. While at work? NO.
(d) Means of injury PEDESTRIAN STRUCK BY AUTO.

23. Signature Thos J. Mullen M.D.
Medical Examiner.
Date signed FEBRUARY 17, 1945.

Huntington Williams, M.D.

VS 151

X

625970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625970 / 94a

Registered No. 625970

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3411 Mondawmin Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 8
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3411 Mondawmin Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Maude Pitcher Gohlinghorst

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Herman Gohlinghorst

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1875.

8. AGE: Years 69 | Months 3 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name James M. Pitcher
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Ann Key
15. Birthplace Baltimore, Md.

16 (a) Informant Edna P. Crawford
(b) Address 3411 Mondawmin Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) ____ (b) ____
(Signature of local registrar)

FEB 17 1945

Thaddeus Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1945, at ____ M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1945 to Feb 14 1945, and that I last saw h[illegible] alive on Feb 14 1945.

Immediate cause of death	Duration
Coronary Thrombosis	5 1/2 hrs
Due to arterio-Sclerosis	several years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. Lukoke Ewell M. D.
Address 2945 St. Paul St. Date signed

X

625971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

625971 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1722 E. 25th street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County - -
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 E. 25th street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME E. ROBERT LINKE

3 (b) If veteran, name war	3 (c) Social Security Account No.
-----	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Edna Hoffman Linke
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1886

8. AGE: Years	Months	Days	If less than one day
58	3	14	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Martin Linke
13. Birthplace Germany

MOTHER
14. Maiden Name Babette Neukem
15. Birthplace Germany

16 (a) Informant Mrs. Edna Hoffman Linke
(b) Address 1722 E. 25th street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem'
Location Balto. Md.
18 (a) Funeral director J. Evans Sons
(b) Address 118 W. Mt. Royal Ave

19 (a) (Date received by Registrar) FEB 17 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1943 to Feb 15 1945.
and that I last saw h[illegible] alive on Feb 14 1945.

Immediate cause of death Acute Cardiac Dil. — Duration 1 day.
Due to Hypertensive Heart Disease — 2 yrs.
Due to Arterio-Sclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. N. Meyer Jr.
Address 1521 E 33rd. Date signed 2/16/45. M. D.

Huntington Williams, M.D.

VS 150

625972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 625972

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
Dead on Arrival
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 Whatcoat Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carol Irene Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1944

8. AGE: Years | Months: 11 | Days: 26 | If less than one day: hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alfred Jones
13. Birthplace Newark, N.J.

MOTHER
14. Maiden Name Jean Graves
15. Birthplace Newark, N.J.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 2-17-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location City

18 (a) Funeral director Saml. W. Chase & Son
(b) Address 638 N. Gilmor St. Washington Metropolitan Area

19 (a) FEB 17 1945
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15, 1945 at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15, 1945 to Feb. 15, 1945. and that I last saw her alive on Feb. 15, 1945

Immediate cause of death	Duration
Pneumonia Abc ?	
Due to Hepatitis Fatal ?	
Due to (one)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pneumonia + Hepatitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clifton R. Graham M. D.
Address 1300 E 41st Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

65973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 65973

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: LBGH. 24-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1243 Hanbert St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William T. Shaw

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-01-6648

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1893

AGE: Years	Months	Days	If less than one day
51	#2	16	hr. min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Good Year Rubber Co.

FATHER
12. Name Robert Shaw
13. Birthplace England

MOTHER
14. Maiden Name Hannah Alcott
15. Birthplace England

16 (a) Informant Mrs. Elizabeth Shaw
(b) Address 1243 Hanbert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/45 (month) (day) (year)

(c) Cemetery or crematory London Park Cem.
Location Frederick Ave.

18 (a) Funeral director Chas. F. Dill
(b) Address 1501 E. Fort Ave.

19 (d) FEB 17 1945 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14-1945 at 12 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14-1945 to 2-14-1945 and that I last saw h / Healive on 2-14-1945

Immediate cause of death	Duration
Cerebral Hemorrhage	1 hr.
Due to hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D Ehrlich M. D.
Address 1213 Light Date signed 2-14-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful[illegible] correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

X

G25974

YA-91910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30D

G25974

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

BALTIMORE CITY HOSPITALS 22-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 613 S. Green St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Jackson Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 10, 1870

8. AGE: Years	Months	Days	If less than one day
74	11	5	hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Peter Clark (d)

13. Birthplace South Carolina

MOTHER

14. Maiden Name Louise Bennett (d)

15. Birthplace South Carolina

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Removal (b) Date thereof 2/17/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Sumter South Carolina

18 (a) Funeral director Isaac L Brown Son

(b) Address 1058 Montgomery Street

FEB 17 1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15, 1945 at 7:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1, 1945 to Feb. 15, 1945 and that I last saw him alive on Feb. 15, 1945.

Immediate cause of death	Duration
dissecting aortic aneurysm & rupture	?
Due to	
Due to	
Other Conditions pericarditis; hypertensive cardiovascular disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. E. Perry, Jr. M. D.

Address City Hosp. Date signed 2-15-45

625975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 625975

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 Briscoe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/10/1880

8. AGE: Years	Months	Days	If less than one day
65	-	3	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Harry Smith
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Alice Harris
15. Birthplace Va

16 (a) Informant George Smith Harris
(b) Address 1109 Briscoe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. Co Md

18 (a) Funeral director Isaiah L Brown Son
(b) Address 1056 Montgomery Street

19 (a) FEB 17 1945 (Date rec'd by Registrar) (b) Huntington Hilliard (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1945, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arterio sclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. Mitchell M.D. Medical Examiner.

Date signed 2/14/45

625976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 625976

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3000 Annapolis Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3000 Annapolis Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George D. Forester

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Fannie Forester
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 15, 1883

8. AGE: Years	Months	Days	If less than one day
61	3	0	hr. min.

9. Birthplace Calvert County Md (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name John Forester
13. Birthplace Calvert County Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Calvert County Maryland

16 (a) Informant Fannie Forester
(b) Address 3000 Annapolis Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 19. 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location City Baltimore

18 (a) Funeral director Joseph A. Lively
(b) Address 1099 Mount Street

19 (a) FEB 17 1945 (Date received by registrar) (b) Interment, Removal, Cremation

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1945, at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to Feb 15 1945 and that I last saw h[illegible] alive on Feb 15 1945.

Immediate cause of death	Duration
(a) Arteriosclerotic Fibrillation	3 mnths
Due to (b) Arteriosclerotic C.V.D	10 yrs
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address [illegible] Date signed 2/17/45 M. D.

VS 8

25977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. 25977

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3718 Guyon Oak Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3718 Guyon Oak Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara M. Stokes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Harry L. C. Stokes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 11, 1869

8. AGE: Years	Months	Days	If less than one day
76	-	4	hr. min.

9. Birthplace Carroll County, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Q. Senseney
13. Birthplace Maryland

MOTHER
14. Maiden Name Marian B. Howard
15. Birthplace Maryland

16 (a) Informant Mr. Howard S. Stokes
(b) Address 425 N. Jackson St. Arlington, Va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 17, 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wilkins-Lawrence Co.
(b) Address 1 W. Lexington St. Baltimore, Md.

19 FEB 17 1945 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1945, at 3.15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945 to Feb 15 1945, and that I last saw h[illegible] alive on Feb 15 1945.

Immediate cause of death	Duration
Toxemia from [illegible]	1 week
Due to Carcinoma of Head of Pancreas	6 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(c) Means of injury

23. Signature A. C. Smith M. D.
Address 4509 Belle Ter. Date signed Feb 16

625978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V48B

Registered No. 625978

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied—correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ky — (b) County
(c) City or town Cynthiana
(If outside city or town limits, write RURAL and give town)
(d) Street No. 304 E Pleasant St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Peddicord

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Carl Peddicord

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-19-89

8. AGE: Years 55 | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace Ky — (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Francis McKlhaney.
13. Birthplace ?

MOTHER
14. Maiden Name Blanche W. Shapp.
15. Birthplace Ky —

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/17/45 (month) (day) (year)

(c) Cemetery or crematory
Location Winchester, Ky.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Penna. Aves

19 (a) Date rec'd by local registrar FEB 17 1945 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16. 1945. at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15- 1945 to 2-16 1945 and that I last saw h[illegible] alive on 2-16. 1945.

Immediate cause of death	Shock	Duration
Due to	Hemorrhage	
Due to	Carcinoma uterus	
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Newton Long MD
Address Johns Hopkins Hosp. Date signed 2/17/45

X

3442366259 79 BALTIMORE CITY HEALTH DEPARTMENT X G25979 79

CERTIFICATE OF DEATH 133a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town New Midway (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A Stover

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	W

6 (b) Name of husband or wife Mattie A Stover
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24 1873

8. AGE: Years	Months	Days	If less than one day
71	5	23	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation farmer
11. Industry or business

FATHER
12. Name Abston Stover
13. Birthplace Md

MOTHER
14. Maiden Name ? Bussard
15. Birthplace Pa

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 20 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Hope Cemetery
Location Woodsboro, Md.

18 (a) Funeral director Burall & Hartzler
(b) Address Woodsboro, Md.

19 FEB 18 1945 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 17 - 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16- 1945 to 2-17- 1945 and that I last saw him alive on 2-17- 1945

Immediate cause of death Resp. failure — Duration

Due to Uraemia — Convulsions

Due to Pyelonephritis, Chronic

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P Whittlesey
Address 177 W. Date signed 2-18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 180

625980 BALTIMORE CITY HEALTH DEPARTMENT 625980

CERTIFICATE OF DEATH 108

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
Monument & Rutland Ave 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4005 Norfolk Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lottie Seidenman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Nathan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Wife

FATHER
12. Name Louis Jacobs
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Milton Seidenman
(b) Address 4005 Norfolk Ave

17 (a) Burial (b) Date thereof Feb, 18, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Date received by registrar (b) Huntington Williams, M.D.

FEB 18 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-17 1945, at 11:23 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2 1945 to 2-17 1945, and that I last saw her alive on 2-17 1945

Immediate cause of death Gastro-Intestinal Hemorrhage — Duration

Due to Myocardial failure

Due to Organizing Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: as above

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jerome P. Walker M. D.
Address Sinai Hospital Date signed 2/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG. RESERVED FOR BINDING

625931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

625931 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St

(c) Hospital or institution Sinai Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2428 Fairview Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Murray GOLDBERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
41			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Store Keeper

11. Industry or business

MOTHER / FATHER

12. Name Melvin

13. Birthplace Russia

MOTHER

14. Maiden Name Pauline

15. Birthplace Russia

16 (a) Informant Hope Records

(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-17-45 (month) (day) (year)

(c) Cemetery or crematory New York City

Location

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 E. Baltimore St

19 (a) FEB 18 1945 (Date rec'd by Local Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 1945, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1945, to 2/17 1945, and that I last saw h[illegible] alive on 2/17 1945.

Immediate cause of death Uremia

Duration

Due to Chronic Glomerulo-nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Philip H. Lerman M. D.

Address [illegible] Date signed 2/17

Philip H. Lerman

VS 150

AB-92156 G25932

BALTIMORE CITY HEALTH DEPARTMENT G25932

CERTIFICATE OF DEATH 133a (ava)

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 Wilcox St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Naomi Zahn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28- 1891

8. AGE: Years 53 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Martin Buch (D)
13. Birthplace ?

MOTHER
14. Maiden Name Mary ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) SUNNYSLOPE CEM. (b) Date thereof TUESDAY FEB. 20 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SUNNYSLOPE CEM.
Location WEST POINT VA.

18 (a) Funeral director ARTHUR-CHALKEY
(b) Address WEST-POINT-VA.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16- 1945 at 6.15PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15- 1945 to 2-16- 1945, and that I last saw her alive on 2-16- 1945.

Immediate cause of death	Duration
Pulmonary Edema	
Due to /	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature /
M. D.
Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

111a

G25933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 | 13

G25933
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 years
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos 29 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Gettysburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 52 Steinwehr Ave. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Elizabeth Linga

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~or wife~~ George Earnest Linga
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1893

8. AGE: Years	Months	Days	If less than one day
51	10	24	11 hr. 55 min.

9. Birthplace Adams County, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Bowling
13. Birthplace Fairfield Adams County, Pa.

MOTHER
14. Maiden Name Alice Mocleaf
15. Birthplace Fairfield Adams County, Pa.

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Road - Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 20, 1945 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Fairfield Catholic Cem
Location Fairfield, Adams Co. Penna

18 (a) Funeral director Francis H. Neurel
(b) Address Gettysburg, Maryland.

19 (a) FEB 18 1945 (Date rec'd by registrar) (b) Huntingtown Md. Feb 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1945, at 11:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1928, to Feb. 17 1945, and that I last saw her alive on Feb. 17 1945.

Immediate cause of death Chronic Glomerulonephritis — Duration 1 year
Due to
Due to
Other Conditions Schizophrenia (Paranoid) — Duration 18 years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel P. Clay Co. M. D.
Address 33 W. Jefferson St. Date signed

V8 3

625984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122

625984 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623 W. Mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ollie Custis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 45 | Months 44 | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER
12. Name James Custis
13. Birthplace Accomac Co. Va.

MOTHER
14. Maiden Name Annie Colson
15. Birthplace Va

16 (a) Informant John Custis
(b) Address 736 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 18, 1945 (month) (day) (year)

(c) Cemetery or crematory
Location Accomac Co. Va.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

19 (a) FEB 18 1945 (Date rec'd by registrar) Huntington Hospital

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 19 45, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1945, to Feb 15 1945 and that I last saw h[illegible] alive on Feb 14 1945

Immediate cause of death: Cardio-muscular Disease — Duration 1 yr
Due to: Nephritis (?)
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Jno. Julian Jr. M. D.
Address 511 N. Eutaw St. Date signed 2/17/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G25985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. G25985

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4309 Maine Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4309 Maine Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: SARAH M. CHAPMAN WARREN

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Calvin C. Warren
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1877

8. AGE: Years about 68 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Smithfield, Va. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Rebecca Chapman
15. Birthplace Unknown

16 (a) Informant Mrs. Edward Joyner
(b) Address Norfolk, Va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 17, 1945 (month) (day) (year)
(c) Cemetery or crematory -
Location Norfolk, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) Date received by registrar FEB 18 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16, 1945, at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1945 to Feb 16 1945, and that I last saw h[illegible] alive on Feb 15 1945

Immediate cause of death: Myocardial degeneration — Duration: 1 day
Due to: Bronchitis — 15 yr
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. E. Joyner M.D.
Address 2818 St. Paul's Date signed 2/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

468537 G25986

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

121a

G25986 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Martins Ferry (If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. #1 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mabel.
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 11-20-97

8. AGE: Years	Months	Days	If less than one day
47	2	26	hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Inspector
11. Industry or business

FATHER 12. Name George R. Davis
FATHER 13. Birthplace Ill.

MOTHER 14. Maiden Name Carrie ? ?
MOTHER 15. Birthplace Ill.

16 (a) Informant Brenda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17 /45 (month) (day) (year)
(c) Cemetery or crematory West Conte Gibby, Md.
Location
18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw

FEB 18 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 16 1945 at 6.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2. 1945 to Feb 16 1945 and that I last saw him alive on Feb - 16 1945.

Immediate cause of death	Duration
Pulmonary edema	
Due to Hypertensive cardiovascular disease with cardiac	
Due to enlargement + failure.	
Other Conditions Uremia Arteriosclerotic nephrosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Cardiac hypertrophy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Hatten M.D.
Address Johns Hopkins Hosp. Date signed 2/17/45

VS 150

G25987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G25987

Registered No.

MARK "X" IN SPACE RESERVED FOR BLACK INK. Every item of information should be carefully supplied. The PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1721 Cliftview ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1721 Cliftview ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E. Jackson, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25 1873

8. AGE: Years 71 | Months 11 | Days 2421 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Store - keeper

11. Industry or business

FATHER 12. Name James Jackson

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs. B. M. Horn.

(b) Address 1721 Cliftview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/45 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location North Ave - above Milton Ave

18 (a) Funeral director Howard N. Blight Jr.

(b) Address 4914 Belair Road

19 (a) FEB 18 1945 (Date rec'd by registrar) Hunter Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1945 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1945 to 2/16 1945, and that I last saw him alive on 2/15 1945

Immediate cause of death	Duration
Acute pulmonary edema	24 hrs.
Due to Arteriosclerotic heart	?
Due to disease	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Mary Baum M. D.

Address 1501 N. Milton Ave Date signed 2/17/45

VS 150

X

G25988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

Registered No. G25988

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood and Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 7days
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County: Baltimore
(c) City or town: Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No.: Wilson Point Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Mary Roesch

3 (b) If veteran, name war:

3 (c) Social Security Account No.: —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 26, 1915

8. AGE: Years: 29 | Months: 5 | Days: 17 | If less than one day: 20 hr. min.

9. Birthplace: Texas (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: George Nelson
13. Birthplace:

MOTHER
14. Maiden Name: Clara Nelson
15. Birthplace: Dallas, Texas

16 (a) Informant: John Roesch
(b) Address: Wilson Point Rd. Middle River

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2/19/45 (month) (day) (year)
(c) Cemetery or crematory: Moreland Park
Location: Taylor ave

18 (a) Funeral director: Harry N. Blight Jr
(b) Address: 4914 Belair Road

19 (a) FEB 18 1945 (Date received by registrar) (b) Registrar: Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 15 1945, at 11 95 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 8 1945 to Feb. 15 1945, and that I last saw h.e.r. alive on Feb. 15 1945

Immediate cause of death: Respiratory Failure — Duration: 1 mos.

Due to: Chorio epithelioma of uterus

Due to:

Other Conditions: Metastasis to lungs

(Include pregnancy within 3 months of death)

Date of operation: Not done

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?: (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Millard J. Fralon M. D.

Address: University Hospital Date signed: 2/16/45

625989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1210

625989 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR RECORDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23 Wickham Rd
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yr 8 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 23 Wickham Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John James Bauer

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Mary Reidel Bauer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18-1861

8. AGE: Years 83 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore County Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Joseph A. Bauer
13. Birthplace Balto. County Md.

MOTHER
14. Maiden Name Mary C. Bruder
15. Birthplace Baltimore Co. Md.

16 (a) Informant Gertrude Bauer
(b) Address 23 S. Wickham Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-1945 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Flanagan
(b) Address 1426 Light St.

19 (a) FEB 18 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1945, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to Feb 16 1945 and that I last saw h— alive on Feb 16 1945

Immediate cause of death	Duration
Cardio vascular Renal Disease	
Due to Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alvin H. Lennartson M. D.
Address 4709 Hudson Ave Date signed 2-19-45

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 625990

CERTIFICATE OF DEATH 462

Registered No. 625990

625990

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 1/23/45
(e) Length of stay in Baltimore (yrs., mos., or days) Since 1/23/45

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town Gloucester
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Alpine Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM KEATING

3 (b) If veteran, name war -

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Susie Fisher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.17, 1891

8. AGE: Years 54 | Months 0 | Days 0 | If less than one day hr. min.

9. Birthplace ? Canada
(Town, county, and state)

10. Usual Occupation AB Seaman

11. Industry or business Merchant Marine

FATHER
12. Name Nicholas Keating
13. Birthplace Canada

MOTHER
14. Maiden Name Mary McGrath
15. Birthplace Canada

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 2-18-1945 (month) (day) (year)

(c) Cemetery or crematory -
Location Gloucester Mass.

18 (a) Funeral director Flynn & Flynn
(b) Address 1426 Light St.

19 FEB 18 1945 (Date rec'd by registrar) (b) Huntington Wells Morticians, M.D.

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Feb. 17, 1945, at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23, 1945 to Feb.17, 1945, and that I last saw h im alive on Feb. 17, 1945

Immediate cause of death Ca of stomach with generalised metastases — 7 Duration 7 Mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leo Mantyla
Address Baltimore, Md. Date signed 2/17/45

MS-46847

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

625991
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1603 Patapsco St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 6
(e) Length of stay in Baltimore (yrs., mos., or days) All 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 Patapsco St
(If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Sophia Meyers

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Charles A Meyers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Work

11. Industry or business

FATHER 12. Name ? Fraulich
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs Meyers
(b) Address 1603 Byrd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Pulaski Highway

18 (a) Funeral director John L Thayhorn
(b) Address 3711 Eastern Ave

19 (a) FEB 18 1945 (Date received by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/16/45, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1944 to Feb 1945, and that I last saw her alive on Feb 15 1945.

	Duration
Immediate cause of death Bronchopneumonia	5 Days
Due to Cerebral Hemorrhage	Indef.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. E. Campbell M. D.
Address 1644 Hanover St Date signed 2/17/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG. RESERVED FOR BINDING

G25992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56B

Registered No. G25992

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 547 Fulton avenue
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Elsie M. Wink

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband Lewis E. Wink

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9th 1890

8. AGE: Years	Months	Days	If less than one day
55	1	6	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name George Chenoweth
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Amanda Mize
15. Birthplace Md.

16 (a) Informant Lewis E. Wink
(b) Address 547 N. Fulton Ave

17 (a) Burial (b) Date thereof 2/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) FEB 18 1945 (b).....
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 1945, at 4 P.M.

21. I certify that I took charge of the remains described above, held an Inspection by Inquiry on the 16th day of February and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Purulent Peritonitis

Due to.....

Other Conditions Strangulated, pedunculated Fibromyoma

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 2-16-45

VS 151

B

129

G25993 G25993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 302 E. 26th st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 302 E. 26th st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Sylvia Wells

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband ~~or wife~~ James Wells Jr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 3rd 1887

8. AGE: Years	Months	Days	If less than one day
57	2	12	hr. min.

9. Birthplace Belair Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name William H. Doxen
13. Birthplace Belair Md.

MOTHER
14. Maiden Name (Not Known) Tucker
15. Birthplace Md.

16 (a) Informant James S Wells
(b) Address 302 E. 26th st.

17 (a) Burial (b) Date thereof 2/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Catonsville Md

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul st

19 (a) FEB 18 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15th 1945, at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1945 to Feb 15 1945 and that I last saw h[er] alive on Feb 14 1945

Immediate cause of death	Duration
Myocardial degen	1 yr
Due to Coronal arteriosclerosis	5 yrs
Due to Enlarged Heart	10 yrs
	1 yr 4
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H G Jones MD
Address 2 St Paul Date signed 2/26/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G25994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G25994 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d + Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ——
(c) City or town Baltimore, 12, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5408 Parlington way.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ——

3 (a) FULL NAME MRS. Bertha mary Ritter

3 (b) If veteran, name war ——
3 (c) Social Security Account No. ——

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Widowed

6 (b) Name of husband or wife Howard Ritter
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) 6-5-1880

8. AGE: Years	Months	Days	If less than one day
64 63	8	11	——hr. ——min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business ——

FATHER
12. Name Mr. George Wm. Dell
13. Birthplace Md.

MOTHER
14. Maiden Name Clara E. Dunbara
15. Birthplace Md.

16 (a) Informant Daughter
(b) Address same as above

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 2/19/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) FEB 18 1945 (Date received by Registrar) (b) ——— Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1945, at 7:10 ~~P~~ M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7 1945, to 2-16 1945, and that I last saw her alive on 2-16 1945.

Immediate cause of death	Duration
Ranimony Failure	
Due to Heart Failure	
Due to Old Myocardial Infarct	
Other Conditions Arterio-sclerosis Peripheral Embolism	

(Include pregnancy within 3 months of death)

Date of operation ——
Major findings of operation: ——
of autopsy: ——

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ——
(b) Date of occurrence ——— at ——— M
(c) Where did injury occur? ——— (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ——— While at work? ———
(Specify type of place)
(e) Means of injury ——

23. Signature Geo. Wm. Dunglinson Jr. M. D.
Address 33d E. University Pkwy Date signed 2/16/45

Huntington Williams M.D.

625995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

625995 / 119a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Point (If outside city or town limits, write RURAL and give town)
(d) Street No. 2327 Ruth Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Lou Haris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-23-44

8. AGE: Years | Months: 10 | Days: 22 | If less than one day: hr. min.

9. Birthplace Fla. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles. Haris
13. Birthplace Oxford Alabama. Florida

MOTHER
14. Maiden Name Roucella Barnam
15. Birthplace Alabama.

16 (a) Informant Parents.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) FEB 18 1945 (Date rec'd by registrar) (b) Waiting for Williams, MR Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb-15. 1945, at 8.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-12 1945, to Feb-15-1945, and that I last saw her alive on Feb-15 1945.

Immediate cause of death	Duration
Undiagnosed disease of central nervous system	7 days
Due to Otitis media	
Other Conditions diarrhea, fever convulsions Rickets	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy no gross cause of death

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John R. Birmingham M. D.
Address JHH Date signed 2-16

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G25996

JL - 91479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1240

G25996

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 8

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1929 St. Paul St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Charles Ervin Biggs

3 (b) If veteran, name war: 10

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of ~~husband~~ or wife Isabella Biggs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1886

8. AGE: Years 58 | Months 4 | Days 21 | If less than one day hr. min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Carrollton Distillery

FATHER

12. Name: John Edward

13. Birthplace Md.

MOTHER

14. Maiden Name Rachael Fowler

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/45 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Parkville Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

B 28 1945 (Date rec'd by registrar) (b) Registrar

VS 150

Huntington Williams, Md

MEDICAL CERTIFICATION P

20. DATE OF DEATH Feb. 15. 1945 at 4.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7, 1945 to Feb. 15 1945 and that I last saw h im alive on Feb. 15 1945

Immediate cause of death Hepatic insufficiency — Duration 2yrs.

Due to Laennec's cirrhosis of the liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature C. A. Bury, J. M. D.

Address City Hosp. Date signed 2-16-45

625937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1940

625937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dat
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Minerva Apts - 900 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward D. Powles

3 (b) If veteran, name war: World #1

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Bertha S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14, 1888

8. AGE: Years	Months	Days	If less than one day
56	2	2	hr. min.

9. Birthplace: Baltimore MD
(Town, county, and state)

10. Usual Occupation: Accountant

11. Industry or business:

FATHER
12. Name: Andrew D. Powles
13. Birthplace: Md

MOTHER
14. Maiden Name: Louisa R. Hummel ~~Bixby~~
15. Birthplace: Catonsville ~~Md~~

16 (a) Informant: Lionel B. Powles
(b) Address: 3708 Echodale Rd

17 (a) Final disposition: Burial
(Burial, cremation, or removal)
(b) Date thereof 2/20/45
(month) (day) (year)

(c) Cemetery or crematory: London Park
Location: Baltimore MD

18 (a) Funeral director: Wilbur Corpse
(b) Address: 214 E Lond

B 10293

19 (a) (Date rec'd by registrar) Hunting Williams MD Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/16 1945, at 9:45 M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.

Date signed 2/16/45

(over)

G25998

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

137a

G25998 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore #16 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2862 W. Lanvale St., #16 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Lee Burgess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of ~~husband or~~ wife Hattie Belle Burgess
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20th 1879

8. AGE: Years	Months	Days	If less than one day
65	6	26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Haywood & Wakefield

FATHER
12. Name William H. Burgess
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Susan Young
15. Birthplace Maryland

16 (a) Informant Hospital Chart
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

FEB 19 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1945, at 11:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10-45 to 2-16 1945, and that I last saw him alive on Feb. 16 1945.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Coronary thrombosis	
Due to Hypertensive cardio-vascular disease	
Other Conditions Benign prostatic hypertrophy	

(Include pregnancy within 3 months of death)
Date of operation 2-14-45
Major findings of operation: Benign prostatic hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John D. Morris M. D.
Address Amd Date signed 2-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 130

625999 Gonyer 625999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56 B

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County None
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1634 Shadyside Rd.
(Or other location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mrs. Gertrude Agnes Gonyer

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married, widowed,~~ divorced: Divorced

6 (b) Name of husband or wife: Forrest

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 21, 1894

8. AGE: Years 50 | Months 5 | Days 26 | If less than one day: ..... hr. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business .....

FATHER
12. Name William Fleet Schools
13. Birthplace Virginia

MOTHER
14. Maiden Name Gertrude W. Tallis
15. Birthplace Virginia

16 (a) Informant Mrs A. D. Howe
(b) Address 1634 Shadyside Rd

17 (a) Burial, ~~cremation, removal~~ (b) Date thereof 2/19/45 (month) (day) (year)
(c) Cemetery ~~Crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) Local registrar (Signature of registrar) Thurlington Williams, M.D. Registrar

FEB 18 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1945, at 2.48 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9 1945, to 2/16 1945, and that I last saw her alive on 2/16/1945.

Immediate cause of death Pulmonary Embolism ..... Duration .....

Due to Thrombosis Rt. Iliac Vein ....

Due to ....

Other Conditions ....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: Fibroma of Uterus

of autopsy: Thrombosis Rt. Iliac Vein

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Charles C. Shaw Jr, M.D.
Address Md. Gen. Hospital Date signed 2/16/45 M. D.

X

626000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 115c

626000 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 So. Highland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorris Hemmings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-22-43

8. AGE: Years 1 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Hemmings
13. Birthplace Maryland

MOTHER
14. Maiden Name Dorris McCann
15. Birthplace Virginia

16 (a) Informant JOHNS HOPKINS HOSPITAL RECORDS
(b) Address

17 (a) Burial (b) Date thereof 2/20/45
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (a) FEB 18 1945 (b)
(Date rec'd by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1945, at 4:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1945 to Feb 16 1945 and that I last saw h[illegible] alive on Feb. 16 1945.

Immediate cause of death	Duration
Respiratory failure	4 days
Due to Bronchial Pneumococcal Pneumonitis	
Due to	
Other Conditions? Pertinent information	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Kerr M.D.

Address Date signed 2/20/45

G26001 G26001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green Spring Ave & Belvedere
(c) Hospital or institution: LEVINDALE
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town)
(d) Street No. Green Spring & Belvedere Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie Fleishman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Nathan —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 80 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER — 12. Name —
13. Birthplace Russia

MOTHER — 14. Maiden Name —
15. Birthplace Russia

16 (a) Informant Mrs. Lena Hettrup
(b) Address 1974 Grand Ave., Bronx N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-45 (month) (day) (year)
(c) Cemetery or crematory United Hebrew Cem.
Location Washington Blvd.

18 (a) Funeral director Jas. Lewis Inc
(b) Address 1439 E. Balto. St

19 (a) 18 1945 (b) Registrar's signature Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1945, at 10.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-23 1934, to 2-16 1945, and that I last saw h. alive on 2-16 1945.

Immediate cause of death Arteriosclerosis. Chr. card. vascular disease — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hedwig D Levin
Address Levindale Date signed 2/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FOR B... JR.

G26002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G26002 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1353 Towson Sts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1353 Towson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mathilda Bild.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: John. Bild.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Mar. 14, 1876

8. AGE: Years 68 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace: Hungaria (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden Name: unknown
15. Birthplace: unknown

16 (a) Informant: Mrs. Mary Winkler
(b) Address: 1600 E. Clement St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 19, 1945 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill Cem.
Location: Annapolis Blvd. A.A.Co.

18 (a) Funeral director: Chas. F. Dill.
(b) Address: 1501 E. Fort Ave.

19 (a) 8 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/16/45 19..., at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13/45 19..., to 2/16/ 1945, and that I last saw her alive on 2/15/ 1945.

Immediate cause of death: Cerebral hemorrhage — Duration: 4 days

Due to:

Due to:

Other Conditions: Hypertensive cardio vascular disease. (Include pregnancy within 3 months of death) — 4/9/41

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Harry Diehl, M.D.
Address: 1226 Hanover St. Date signed: 2/17/1945

G26003 BALTIMORE CITY HEALTH DEPARTMENT G26003
CERTIFICATE OF DEATH
50 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St.
(c) Hospital or institution:
Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo. 6 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Howard
(c) City or town Glenelg (If outside city or town limits, write RURAL and give town)
(d) Street No. Frederick Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Fitch

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Hugh R. Fitch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1859

8. AGE: Years 85 | Months 4 | Days 4 | If less than one day hr. min.

9. Birthplace Fiskburg, Kentucky (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business Retired

FATHER 12. Name Hezikiah Wells
13. Birthplace Arkansaw

MOTHER 14. Maiden Name Alameda Hopper
15. Birthplace Kentucky

16 (a) Informant Rev. A. L. Fitch
(b) Address Glenelg Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 19, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. View Cem.
Location Slacks Corner Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.

19 (a) (Date received by registrar) (b) Registrar

FEB 23 1945 WS-3 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17, 1945 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11th 1944 to Feb 16th 1945, and that I last saw h[illegible] alive on Feb 16th 1945.

Immediate cause of death	Duration
Carcinoma of Right Breast	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Sanford
Address 100 N. Melton Date signed 2/18/45 D.

G26004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

G26004 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rosewood State Training School
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME John W. Stockton

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 21, 1915

8. AGE: Years	Months	Days	If less than one day
29	6	27	..... hr. ..... min.

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation Inmate

11. Industry or business Rosewood Training School.

FATHER 12. Name John D. Stockton

13. Birthplace Texas

MOTHER 14. Maiden Name Unice Cowan

15. Birthplace Texas

16 (a) Informant Mrs Lorena Shumate

(b) Address 1207 Geranium St Wash D.C.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 18, 1945 (month) (day) (year)

(c) Cemetery or crematory.....
Location Removal to Silver Springs Md

18 (a) Funeral director Warner E. Pumphrey

(b) Address Silver Springs Md.

FEB 19 1945 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17, 1945, at ..... M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Depressed Fracture of Skull

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Feb. 17, 1945 Baltimore M.

(b) Where did injury occur? Reisterstown Rd near Rosewood Lane

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No

Means of injury Pedestrian struck by auto

23. Signature Robert L. Graham M.D.
Medical Examiner.

Date signed Feb 18 1945

VS 151

TESSITORE

G26005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

Registered No. G26005

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town New York (If outside city or town limits, write RURAL and give town)
(d) Street No. 1950 78th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Tessitore [redacted]

3 (b) If veteran, name war

3 (c) Social Security Account No. 052-07-5291

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	

6 (b) Name of husband or wife Fortunata

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19-1885

8. AGE: Years	Months	Days	If less than one day
59	11	29 28	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Painting

FATHER
12. Name Francesco TESSITORE
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta Martino
15. Birthplace Italy

16 (a) Informant Ralph Giordano 1147 CROSBY AVE
(b) Address Bronx — New York

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2/22/45 (month) (day) (year)

(c) Cemetery or crematory St John's
Location Brooklyn N. Y.

18 (a) Funeral director Frank DeGaetano
(b) Address 52 W. Monroe St.

19 (a) FEB 24 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17th 1945, at 12 50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Ruptured Aorta, traumatic. Ruptured Liver; compound fracture of ribs

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb 17th 1945 1/4 M.
(b) Where did injury occur? Kingsbridge Rd & O'Donnell St 1024-1026
(c) Did injury occur at home, on farm, industrial place, in public place? Church While at work? yes
(d) Means of injury Fell from scaffold

23. Signature Robert A. Gerstein M.D. Medical Examiner.
Date signed Feb 18 1945

VS 151

626006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122 B Registered No. 626006

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Northern Pkwy
(c) Hospital or institution: Maryland Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Katherine Robb Nursing Home (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 4905 Harford Rd.

3 (a) FULL NAME Joseph F. Happel (Joseph F Happel)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1865

8. AGE: Years 79 | Months 3 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Musician

FATHER
12. Name August Happel
13. Birthplace Germany

MOTHER
14. Maiden Name Lena Metz
15. Birthplace Germany

16 (a) Informant Wm. Happel (brother)
(b) Address 4108 Fleet Wood ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location: Belair Road Balto:Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) FEB 19 1945 (Date rec'd by Registrar) (b) Hunterstor Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1945 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1945 to Feb 17 1945, and that I last saw him alive on Feb 07 1945

Immediate cause of death: Generalized cachexia

Due to: Obstruction to bowels

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Mavrikatanis M. D.
Address Maryland Gen. Hosp. Date signed 2/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26007 ✓ G26007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 742 Melville Ave.

(c) ~~Hospital or institution:~~ Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 742 Melvale Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** William Beal Duncan

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-07-4910

4. Sex: M.

5. Color or race: W.

6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~: Married

6 (b) Name of ~~husband~~ or wife: Neva Duncan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27th 1880

8. **AGE:** Years: 64 | Months: 5 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Artist

11. Industry or business: Lithographer

FATHER

12. Name: William Duncan

13. Birthplace: Md

MOTHER

14. Maiden Name: Amelia Tweedale

15. Birthplace: England

16 (a) Informant: Leya Duncan

(b) Address: 742 Melvale Ave

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 3/20/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~: London Park

Location: Balto. Md.

18 (a) Funeral director: William Cook Inc

(b) Address: 1217 St. Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 19 1945

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 18 Feb 1945, at 10th A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1945 to 18th Feb 1945, and that I last saw ~~him~~ alive on 18th Feb 1945

	Duration
Immediate cause of death: Lobar Pneumonia	4 Days
Due to: Cerebral arterio-sclerosis	1½ yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: X at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? X While at work? (Specify type of place)

(e) Means of injury:

23. Signature: Hugo Hooper M. D.

Address: 3543 Hershe Ave Date signed 18 Feb 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G26008 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1158 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida May Hauhn

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Henry J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1875

8. AGE: Years 69 | Months 10 | Days - | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Osborne
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary (Unknown)
15. Birthplace Baltimore Md

16 (a) Informant Emma Hauhn
(b) Address 1158 Washington Blvd

17 Burial (b) Date thereof 2/20/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director Tilhorn Lodge Inc
(b) Address 1217 E. Fayette St

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 19 1945 Thurston Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 1945, at 7:20 A.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McCullough M.D.
Medical Examiner.
Date signed 2/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G26003 — 94Q — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2915 Riggs Ave
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2915 Riggs Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Clarke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband Thomas F. Clarke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24th 1886

8. AGE: Years 58 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name John Siegelin
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Thomas F. Clarke
(b) Address 2915 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/45 (month) (day) (year)
(c) Cemetery ~~or Crematory~~ Trinity
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 1945 at 9.15 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.
Date signed 2/18/45

G26010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G26010

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1544 Division Street

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1136 W. Lexington (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Robert Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Katie Hill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27 1878

8. AGE: Years 66 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Balto., md (Town, county, and state)

10. Usual Occupation Waiter main

11. Industry or business

FATHER 12. Name Robert F. Hill

13. Birthplace md

MOTHER 14. Maiden Name Mary Kennard

15. Birthplace md

16 (a) Informant Katie Hill

(b) Address 1136 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location Baltimore md

18 (a) Funeral director James A. Sayer

(b) Address 142 W. Hill St

19 (a) FEB 19 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16, 1945, at 4:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1945, to 2/16 1945, and that I last saw h alive on 2/16 1945.

Immediate cause of death Hemorrhage from gastrointestinal tract

Due to Carcinoma of Stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. R. Causey, M. D.

Address Provident Hospital Date signed 2/17/45

G26011

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

180 Registered No. G26011

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 Barclay Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME James Thompson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband or wife: Evelyn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8 1896

8. AGE: Years 48 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace Phila Pa. (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business P.R.R.

FATHER
12. Name James E. Thomson
13. Birthplace Scotland

MOTHER
14. Maiden Name Jeanne H. Hall
15. Birthplace Scotland

16 (a) Informant Evelyn Thomson
(b) Address 2420 Barclay St.

17 (a) Cremation (b) Date thereof 2-19-45
~~Burial~~, cremation, or removal (month) (day) (year)
(c) ~~Cemetery or~~ crematory Greenmount
Location Greenmount Bal.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) FEB 19 1945 (b)
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-17- 1945, at 7:00 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Carbon monoxide

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 12/3
(a) Date of injury 2-17-45 at 6.30 A. M.
(b) Where did injury occur? 2420 Barclay Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Conflagration

23. Signature Howard J. Wiesen M.D. Medical Examiner.
Date signed 2-17-45

G2601C ✓ G2601C

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 Harlem ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Butler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Seperated

6 (b) Name of husband or wife: James | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3- -1893

8. AGE: Years 51 | Months 11 — | Days — | If less than one day: hr. min.

9. Birthplace Carroll Co Md
(Town, county, state or foreign country)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name George Nickum
13. Birthplace Md

MOTHER
14. Maiden Name Mary ?
15. Birthplace Md

16 (a) Informant Harry Butler
(b) Address

17 (a) Burial (b) Date thereof 2-20-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave

19 (a) FEB 19 1945 (b) Huntington Williams
(Date rec'd by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16, 1945, at 4.26 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/16 1945 to 2/16 1945, and that I last saw her alive on 2/16 1945.

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. R. Cooney, M. D.
Address Provident Hospital Date signed 2/16/45

X

626013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832 Registered No. 626013

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3023 White Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 yrs 4
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3023 white Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DANIEL V. DOLAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-3161

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Emly E. Dolan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1880

8. AGE: Years	Months	Days	If less than one day
65	-	24	hr. min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)
10. Usual Occupation Linotype Machinist
11. Industry or business A.S. Abell Co.

FATHER
12. Name Michael Dolan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary K. Hammel
15. Birthplace Balto., Md.

16 (a) Informant Mrs. D. V. Dolan
(b) Address 3023 White Ave., Balto.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Feb. 20, 1945 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Balto., Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

19 (a) FEB 19 1945 (Date received by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17th 1945 at 6:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feby 12 1945 to Feby 17 1945 and that I last saw him alive on Feby 17 1945

Immediate cause of death Cerebral Hemorrhage (Apoplexy) — Duration Feby 16 1945

Due to

Due to

Other Conditions Arteriosclerosis — a Number of Years

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury

23. Signature Morris B. Green M. D.
Address 3009 Evergreen Ave Date signed 2/17/45
Baltimore 14, Maryland.

Huntington Williams M.D.

G66014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G66014

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3814 Greenmount Avenue

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County ---

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3814 Greenmount Avenue (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Laura A. Rowland

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Frank B. Rowland

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 3, 1881

8. AGE: Years	Months	Days	If less than one day
63	10	14	hr. min.

9. Birthplace Lock Haven, Pa. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name William Boone

13. Birthplace Lock Haven, Pa.

MOTHER

14. Maiden Name Martha Gardner

15. Birthplace Lock Haven, Pa.

16 (a) Informant Mrs. Dorothy R. Gaither

(b) Address 3814 Greenmount Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/20/45 (month) (day) (year)

(c) Cemetery or crematory Prospect Hill Cem.

Location York, Pa.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) [illegible] (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17, 1945, at a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 4 1941, to Feb. 17 1945, and that I last saw h[illegible] alive on Dec. 6 1944.

Immediate cause of death	Duration
Hypertensive cardiovascular disease	
with auricular fibrillation	12 yrs.
Due to	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: None done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John Tilden Howard M. D.

Address 12 E. Eager St Date signed Feb. 19, 45

VS t50

626015 ✓ 626015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 911 N. Russell
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 911 N. Russell (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Mivens
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/16/45

8. AGE: Years | Months | Days | If less than one day hr. 5 min.

9. Birthplace 911 N. Russell (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Stephan Mills
13. Birthplace Orangeburg S.C.

MOTHER
14. Maiden Name Ozile Rivers
15. Birthplace Summerton S.C.

16 (a) Informant Ozile Mivens
(b) Address Summerton S.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto, Md.

18 (a) Funeral director Charles L. Law
(b) Address 802 Madison Ave.

19 (a) [illegible] Huntington Williams, M.D. Registrar
FEB 19 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/16/45 at 8:25 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 2/16/45 19 , and that I last saw him alive on 2/16/45 19 .

Immediate cause of death Premature Birth — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation None

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hallcome M. D.
Address 1131 Harlem Road Date signed 2/17/45

"No prenatal care" X

G26016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Registered No. G26016

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3721 Hilldale Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Keen Lutz

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Frederick M. Lutz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1872

8. AGE: Years	Months	Days	If less than one day
72	4	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation --
11. Industry or business

FATHER
12. Name Albert T. Ports
13. Birthplace Hampstead, Md.

MOTHER
14. Maiden Name Louisa Keen
15. Birthplace Balto.Co., Md.

16 (a) Informant Mr. John F. Lutz
(b) Address 4407 Wentworth Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 19 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-17-1945 at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13-1945 to 2-17-1945, and that I last saw h[illegible] alive on 2-17-1945.

Immediate cause of death: Respiratory failure
Terminal
Due to Lobar Pneumonia
Due to Bleeding gastric ulcer
Other Conditions Arteriosclerotic Heart Disease (Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Terminal Lobar Pneumonia
of autopsy: Gastric ulcer

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen C. Wooden M. D.
Address W B & H Date signed 2-17-45

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G26017

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 N. Longwood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 N. Longwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM EDWARD BENTZ

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Margaret A. Bentz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1872

8. AGE: Years	Months	Days	If less than one day
73	0	2	hr. min.

9. Birthplace York, Pa.
(Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business

FATHER
12. Name Bentz
13. Birthplace

MOTHER
14. Maiden Name Amanda
15. Birthplace

16 (a) Informant Mrs. Marie A. Cops
(b) Address 511 N. Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/45 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 19 1945 (Date received by registrar) (b) [illegible] for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16, 1945, at 2:15P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1944, to 2/16 1945, and that I last saw h[illegible] alive on 2/16 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	7 days
Due to arteriosclerosis	2
Due to Hypertension	8
	1
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Tankersley M. D.
Address 100 N. Madeira Date signed 2/19/45

VS 150

For P.H.B.: McNally by Howard S. Maddux, M.O.

G26018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. G26018

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4114 Reisterstown Rd.
(c) Hospital or institution:

1542

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4114 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Buettner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Theresa Buettner
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) June 2, 1876

8. AGE	Years	Months	Days	If less than one day
69	~~68~~	8	14	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name ~~Unknown~~ John J. Buettner
13. Birthplace Germany

MOTHER
14. Maiden Name ~~unknown~~ Jenney Britting
15. Birthplace Germany

16 (a) Informant Mrs. Theresa Buettner
(b) Address 4114 Reisterstown Rd.

17 (a) Burial (b) Date thereof 2/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Le Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) FEB 19 1945 (b) Huntington Williams, M.R.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1945, at 3.57 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1945 to 2/16 1945, and that I last saw him alive on 2/16 1945.

Immediate cause of death Uremic Nephritis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify exact place)
(e) Means of injury

23. Signature Thos D Bubert M. D.
Address 4803 Park Heights Date signed

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D

YA-92006 626019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 46 B

626019 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4413 Ivanhoe Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joshua Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1862

8. AGE: Years	Months	Days	If less than one day: hr.	min.
82	8	4	18	

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Joshua (d)

13. Birthplace Md.

MOTHER

14. Maiden Name Rachel Harris (d)

15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) (Burial, cremation, or removal) (b) Date thereof 2-19-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cemetery

Location Baltimore Md.

18 (a) Funeral director Archibald G. Gaddis

(b) Address 2101 Mc Culloh St

19 (a) FEB 19 1945 (Date received by Registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH February 15, 1945, at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7, 1945, to Feb. 15, 1945 and that I last saw him alive on Feb. 15, 1945.

Immediate cause of death	Duration
Hemorrhage from	5 min.
Due to Ca Stomach	2
Due to	
Other Conditions Hypertensive cardiovascular degeneration extreme cachexia	2 mo.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. Woodward M. D.

Address Baltimore City Hospitals Date signed 2-16-45

VS 180

5

X

G26020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5213 Registered No. G26020

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812 N.Pat.Park Ave.
(c) Hospital or institution:

713

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812 N.Pat.Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Hubbel

3 (b) If veteran, name war --

3 (c) Social Security Account No. 00***

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Geo.J.Hubbel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec.15,1890

8. AGE: Years 54 | Months 2 | Days 0 | If less than one day hr. min.

9. Birthplace Balto.Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Geo.Klueber
13. Birthplace Balto.Md.

MOTHER
14. Maiden Name Minnie Degele
15. Birthplace Balto.Md.

16 (a) Informant Geo.J.Hubbel
(b) Address 812 N.Pat.Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb.19/45 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto.Md.

18 (a) Funeral director Philip Herring Sons
(b) Address 2024 Orleans Street

19 (a) FEB 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb.15th.1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to Feb 15 1945 and that I last saw h[illegible] alive on Febr 4 1945.

Immediate cause of death Carcinoma of Bladder

Due to

Due to

Other Conditions Uremia Hypostatic Pneumonia

(If acute pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas B March M.D.

Address 801 N Eutaw Date signed

X

626021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1942

626021 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26 E. Lanvale St.
(c) Hospital or institution: none 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 26 E. Lanvale St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Belle Rowe Marlow

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April , 1852

8. AGE: Years	Months	Days	If less than one day: hr.	min.
82	10			1862

9. Birthplace Mason Springs, Chas. Co., Md. (Town, county, and state)
10. Usual Occupation Public School Teacher
11. Industry or business retired 15 yrs.

FATHER
12. Name James Humphrey Marlow
13. Birthplace Md.

MOTHER
14. Maiden Name Dora Rowe
15. Birthplace Md.

16 (a) Informant Charles Lester Marlow, Jr.
(b) Address 4413 Marble Hall Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Windsor Mill Road

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

FEB 19 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1945, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1937, to 2/16 1945, and that I last saw h[illegible] alive on 2/14 1945

Immediate cause of death	Duration
Coronary Thrombosis	1 hr.
Due to Coronary Sclerosis	7 yrs.
Due to Arteriosclerosis generalized	9 years.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry M. Hansen M. D.
Address 20 E. Preston St. Date signed 2/19/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 60022

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1632 N Montford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 1632 N Montford (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Caroline E Batchelor

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Arthur C Batchelor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/8/1876

8. AGE: Years 69 | Months — | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Geo E Kaiss
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Meyer
15. Birthplace Balto

16 (a) Informant John Kaiss
(b) Address 2220 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 19 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Leimot Funeral Home
(b) Address 2004 E. Orleans St

19 (a) Date received by Registrar FEB 19 1945 (b) Registrar Hunting for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 1945 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1935 to Feb 12 1945, and that I last saw her alive on Feb 12 1945

Immediate cause of death	Duration
Chronic Myocarditis	10 years
Due to Arteriosclerosis	10 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Victor Goldberg M.D. M. D.
Address 3100 Harford Road Date signed Feb 18 '45

G26023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G26023

Registered No. 13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 W. Lexington apt 9
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 800 W. Lexington apt 9
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Holliday

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-6358

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	

6 (b) Name of husband or wife Ethel Hatchett Holliday

6 (c) If alive, give age day years

7. Birth date of deceased (mo., day, yr.) Oct 2, 1906

8. AGE: Years	Months	Days	If less than one day
38	4	15	hr. min.

9. Birthplace S. C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Sugar Refinery

FATHER
12. Name Wm. Holliday
13. Birthplace S. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Ethel Holliday
(b) Address 800 W. Lexington St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/19/45 (month) (day) (year)
(c) Cemetery or crematory Camden, S. C.
Location S. C.

18 (a) Funeral director Katie R. Williams
(b) Address 1945 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

FEB 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1945, at 5 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 29 1945 to Feb 16 1945 and that I last saw him alive on Feb 16 1945

Immediate cause of death Bilateral Pulmonary T.B.C.

Duration
about 15 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert W. Gaines M. D.

Address 666 W. Baltimore Date signed 2/17/45

G26024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G26024

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days).....

(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County.....

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 536 Johannsen St
(If rural give location)

(e) Citizen of foreign country?.....(Yes or No)

If yes, name country.....

3 (a) FULL NAME Elijah Frier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4-3-32

8. AGE: Years 12 | Months 10 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER

12. Name Elijah Frier

13. Birthplace S.C.

MOTHER

14. Maiden Name Maggie Knotts

15. Birthplace S.C.

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Feb. 19, '45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location.....

18 (a) Funeral director Katie R. Williams

(b) Address 322 N. Schroeder St

19 (a) FEB 19 1945 (b)
(Date rec'd by Registrar) Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1945 at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1944 to Feb 15 1945 and that I last saw her alive on Feb 15 1945

Immediate cause of death: Pulmonary tuberculosis

Due to: Tuberculous peritonitis

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

Duration: 4 months

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at..... M

(c) Where did injury occur?.....
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)

(e) Means of injury.....

23. Signature Victor A. Najjar M. D.

Address Johns Hopkins Hosp. Date signed 2-16-45

X Najjar

Dr. Gordy
626025

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46B

Registered No. 626025

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2907 Louise Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2907 Louise Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Pernell Raymond

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Harriet Raymond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1880

8. AGE: Years	Months	Days	If less than one day
64	5	4	hr. min.

9. Birthplace Windber, Pa.
(Town, county, and state)
10. Usual Occupation Retired watchman
11. Industry or business

FATHER
12. Name Francis Raymond
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Harriet S. Raymond
(b) Address 2907 Louise Aveneu

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) FEB 19 1945 (Date received by registrar) Huntington Publishing Co.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1945, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1945 to Feb 19 1945, and that I last saw him alive on Feb 16 1945.

Immediate cause of death Carcinoma of Stomach — Duration 1 year
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury none
23. Signature H. L. Gordy M. D.
Address 5106 Harford Rd Date signed 2-19-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G20020 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fremont Ave and Madison
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City
(c) City or town 725 Hollen Road, Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles C. Porter

3 (b) If veteran, name war	3 (c) Social Security Account No. None
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Lizzie Price
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) June 3, 1880

8. AGE: Years	Months	Days	If less than one day
64	8	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Foreman on City Golf Course
11. Industry or business —

FATHER
12. Name George W. Porter
13. Birthplace Penna.

MOTHER
14. Maiden Name Elizabeth Allgire
15. Birthplace Md.

16 (a) Informant Lizzie Porter
(b) Address 725 Hollen Road, Balto.

17 (a) Burial (b) Date thereof Feb. 20, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Carroll Co. Md

18 (a) Funeral director Wm. Berryman & Sons
(b) Address Reisterstown, Md.

19 (a) (Date received by registrar) (b) (Registrar)

FEB 19 1945 Huntington Hillsdale

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16 1945, at 5:26 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15 1945, to 2-16 1945, and that I last saw him alive on 2-16 1945.

Immediate cause of death Pneumonia — Duration 3 days
Lobar
Due to
Due to
Other Conditions Diabetes mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l Hospital Date signed 2/16/45

108

626027

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1860

626027
Registered No.

Every item of information should be carefully supplied; write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK. Even correctness is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 848 W. Pratt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Geary

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) aug 8th 1900.

8. AGE: Years	Months	Days	If less than one day
44	6	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Phillips Co.

FATHER
12. Name Martin A. Geary.
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Margaret T. McAleer
15. Birthplace Ireland

16 (a) Informant Mrs Margaret T. Geary
(b) Address 848 W. Pratt St —

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 2/22/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Aliceanna St

18 (a) Funeral director John J. Cowan & Son (b) Address 901 E. Fallsway

19 (a) (Date rec'd by registrar) FEB 19 1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18- 1945, at 9.25 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 18/1

(a) Date of injury 2-18-45 at 9.45 P M.
(b) Where did injury occur? 872 W. Balto. St.
(c) Did injury occur at home, on farm, industrial place, in public place? House While at work? No
(d) Means of injury Fell, more than -3½ to 2½

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 2-19-45

VS 151

G26028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G26028

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not neglect age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Laynes Dukeland Sts
(c) Hospital or institution: West Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2829 Winchester St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Backoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Frank E Backoff.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2nd 1913.

8. AGE: Years 31 | Months 5 | Days 14 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business at home

FATHER
12. Name John Mudd
13. Birthplace Maryland

MOTHER
14. Maiden Name Carrie Horney
15. Birthplace Maryland

16 (a) Informant Mr Frank E Backoff.
(b) Address 2829 Winchester St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 2 (month) (day) 45 (year)
(c) Cemetery or crematory Meadowridge
Location Dorsey Md

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 W Pratt St.

19 (a) FEB 19 1945 (Date received by registrar) (b) for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/16 1945; at 7.20 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest (Autopsy, Inspection or Inquest) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating gas

Other Conditions Despondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/16/45 at about 6.30 P M.
(b) Where did injury occur? 2829 Winchester St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Suicide by inhalation of gas from open jet over

23. Signature D. J. Pulaski M.D.
Medical Examiner.
Date signed 2/16/45

VS 151

626029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 626029

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1506 McCleary Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 McCleary St (If rural, give location)
(e) Citizen of foreign country Ukr Ebdbrg (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widow

6 (b) Name of husband or wife Nellie Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23-1895

8. AGE: Years	Months	Days	If less than one day
49	3	23	hr. min.

9. Birthplace St. Mary's Co. Md. (Town, county, and state)
10. Usual Occupation Butler
11. Industry or business

FATHER
12. Name Joseph Brown
13. Birthplace St Mary's Co. Md.

MOTHER
14. Maiden Name Jennie Clark
15. Birthplace St. Mary's Co. Md

16 (a) Informant Settie Waters
(b) Address 1506 McElderry St

17 (a) Burial (b) Date thereof 2 / 19 / 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ridge Md
Location St Mary's Co. Md

18 (a) Funeral director Robt E. Williams
(b) Address 1515 McElderry St

19 FEB 19 1945 (b) Hunter Stone Hollis Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15, 1945 at 11 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed Feb. 16 1945

G26030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G26030 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 908 Prince St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Prince St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Ruff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Jennie V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name John Ruff.
13. Birthplace Belair, Md.

MOTHER 14. Maiden Name Georgianna Marshall
15. Birthplace Balto, Md.

16 (a) Informant Mrs. Thomas Ruff.
(b) Address 917 Prince St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 19, 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (b) Huntington Williams Mt.
(Date rec'd by registrar) (Signature of registrar)

FEB 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1945 at 10 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14/45 to 2/14/45 and that I last saw h[illegible] alive on 2/14/45

Immediate cause of death: Hypertension Cardio Renal — Duration: 1 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. R. Hatcher M. D.
Address Date signed 2/19/45

G26031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G26031 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4215 Fernhill Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 74 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4215 Fernhill Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME H. Edith Fowler Duffield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank G. Duffield

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23/1870

8. AGE: Years 74 | Months 4 | Days 26 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business at home

FATHER 12. Name Charles E Fowler

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden Name Johanna Jones

MOTHER 15. Birthplace Maryland

16 (a) Informant Frank G. Duffield

(b) Address 4215 Fernhill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 21/1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Harry A. Annacott

(b) Address 4204 Edgewood Ave

19 (a) FEB 19 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18, 1945, at 2:55 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11, 1945, to Feb 18, 1945, and that I last saw h[illegible] alive on Feb 17 1945.

Immediate cause of death	Duration
Hypostatic Pneumonia	8 days
Due to Pyuria and suffering,	?
Due to Chronic nephritis	?
Other Conditions Arteriosclerosis with hypertension	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Maurice L. Abrams M. D.

Address 3300 N Charles Date signed 2/19/45

VS 150

G26032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G26032

Registered No. 138

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 S. Bunny St (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME William McKee

3 (b) If veteran, name war.....
3 (c) Social Security Account No. 214-03-1137

4. Sex: M | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1903

8. AGE: Years 41 | Months 3 | Days 13 | If less than one day: ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business .....

FATHER
12. Name Wm McKee
13. Birthplace Ireland

MOTHER
14. Maiden Name R Stengery
15. Birthplace Austria

16 (a) Informant Anna H. McKee
(b) Address 1015 S. Bunny St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/45 (month) (day) (year)
(c) Cemetery or crematory Schwartz
Location O'Donnell St.

18 (a) Funeral director Stephen J. Fitzhugh Inc.
(b) Address 1600 S. Kenwood Ave.

19 (a) ..... (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar) FEB 19 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1945, at 2 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Pulmonary Tuberculosis

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?.....
(d) Means of injury.....

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed Feb 16 1945

G26033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G26033

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1513 Rutland Ave.
(c) Hospital or institution: W. O. S. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt. Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 Rutland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Delbert LeRoy Fogwell (Baby)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male
5. Color or race W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Preston Fogwell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day 16 hr. 30 min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Preston LeRoy Fogwell
13. Birthplace Eastern Shore Md.

MOTHER
14. Maiden Name Lillie Mae Latham
15. Birthplace Balt. Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL FEB 19 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 19 1945 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1945, at 7:05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/18 1945, to 2/18 1945, and that I last saw him alive on 2/18 1945.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Premature - 1 lb 11½ oz	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Don Dejon M. D.
Address 819 Medical Arts Bldg. Date signed 4/9/45

VS 190

2528

G26034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G26034 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 N. Madeira St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jack King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine Travinski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30 - 1898

8. AGE: Years 46 | Months 5 | Days 16 | If less than one day hr. min.

9. Birthplace Rocky Mount N.C. (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business Sparrowspoint

FATHER
12. Name George King
13. Birthplace Rocky Mount. N.C.

MOTHER
14. Maiden Name Willoughby
15. Birthplace N.C.

16 (a) Informant Wife
(b) Address 405 N. Madeira St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21, 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank V. Pipitone
(b) Address 2818 E Balto St

19 (a) FEB 19 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/16 1945, at 7:37 P M

21. I certify that I took charge of the remains described above, held an Inspection - Inquest Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. J. Travinski M.D. Medical Examiner.
Date signed 2/17/45

G26035

TN.

BALTIMORE CITY HEALTH DEPARTMENT

56296 CERTIFICATE OF DEATH ✓ 93c

G26035

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs 8 mos 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 803 South Dallas St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country Poland

3 (a) FULL NAME Catherine Radziewicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept ? 1859

8. AGE: Years	Months	Days	If less than one day
85 86	? 5	?	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name George Plachata (D

13. Birthplace Poland

MOTHER

14. Maiden Name Lucia Doroczokowna (D

15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave) records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 20/45 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem Location Baltimore County

18 (a) Funeral director John M. O'Brien

(b) Address 400 S. Chester Street

19 (a) FEB 19 1945 (Date rec'd by registrar) (b) Arlington Williams M.E. (registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10th, 1945 at 8.45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-5-40 19 to 2-10-45 19, and that I last saw her alive on 2-10-45 19.

Immediate cause of death	Duration
Cachexia	
Pernicious Anaemia	1
Due to Hemorrhage Cerebral	
Due to	
Other Conditions Carcinoma Hyperplasia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. D.

Address Date signed

VS 150

G26036

JL - 81737

To be approved by Medical Examiner.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G26036 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 305 Camel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Figgs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1895

8. AGE: Years 49 | Months 3 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Edward Figgs
13. Birthplace Md.

MOTHER
14. Maiden Name Nellie Gray
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director A. J. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) Date received by Registrar FEB 23 1945 (b) Registrar Winnifred M. Winston, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1945, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 22, 1945 to Feb. 16 1945, and that I last saw h im alive on Feb. 16 1945.

Immediate cause of death: Anesthetics death — Duration: 5 min.
Due to
Due to
Other Conditions — Duration: 2 hours?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/12
(a) Accident, suicide, or homicide Acc
(b) Date of occurrence February 16, 1945 at M
(c) Where did injury occur? Baltimore City (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital While at work? No (Specify type of place)
(e) Means of injury Died during anesthetic

23. Signature
M. D.
Address Date signed

Approved A. Hugh Mcnally M.D. per Robt Le Gendre M.D.

G26037

G26037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 803 South Bethel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Angel Rodriguez

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-5-90

8. AGE: Years	Months	Days	If less than one day
49	3	11	hr. min.

9. Birthplace Porto Rico (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Pablo Rodriguez
13. Birthplace

MOTHER
14. Maiden Name Lop Lenia ?
15. Birthplace

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 20 1945 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn.
Location Eastern ave. Balto
18 (a) Funeral director Mendell & Heppel
(b) Address 312 S. Highland Ave (Signature for Mendell & Heppel)
19 (a) (Signature by registrar) Registrar
(b) 2-19-1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1945, at 11 29 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1945 to Feb. 16 1945, and that I last saw h-im alive on Feb. 16 1945.

Immediate cause of death Contusions of brain & pneumonia following rib fractures. | Duration

Due to | |

Due to | |

Other Conditions Moderate hypertension. | |

(Include pregnancy within 3 months of death)

Date of operation 2/12/45

Major findings of operation: Extension of right cerebral hemisphere.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 2/3

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 2/9/45 at

(c) Where did injury occur? Baltimore Md. M
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? In Street or Traffic (Specify) While at work?

(e) Means of injury Struck by truck

23. Signature Lew W. Chambers M.D.

Address Johns Hopkins Hospital Date signed 2/16/45

Approved: Hugh B. McNally M.D. per Robert Lee Graham M.D.

G26038

BALTIMORE CITY HEALTH DEPARTMENT

G26038 CERTIFICATE OF DEATH 94a Registered No. G26038

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3117 Ferndale Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3117 Ferndale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Helen Grelck

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William P. M. Grelck
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) June 20, 1877

8. AGE: Years	Months	Days	If less than one day
67	7	26	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER 12. Name Mr. Paul Karstens
15. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Wm. P. M. Grelck
(b) Address 3117 Ferndale Road

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof Feb. 20, 1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miller & Amoroso
(b) Address 4510 Liberty Heights Ave.

19 (a) Huntington Williams, M.D. (b)
(Date rec'd by registrar) Registrar

FEB 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1945, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1944 to Feb 16 1945, and that I last saw her alive on 2/16 1945.

Immediate cause of death	Duration
Acute cardiac dilatation	
Due to Coronary thrombosis	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Wenick M. D.
Address 4501 Springdale Ave. Date signed 2/17/45

VS 150

626039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 626039 Registered No. 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 58 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen (Ella) Lavinia Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.
———	———

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27 1865 (80)

8. AGE: Years	Months	Days	If less than one day
79	2	30 21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Christian J. Smith, Jr.
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Wineberger (Elisabeth C. Weinberg)
15. Birthplace ~~Baltimore, Md.~~ Germany

16 (a) Informant ~~Hosp. chart.~~ Miss Cora A. Smith
(b) Address 3206 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 19, 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller & Leonard
(b) Address 4510 Liberty Heights Ave.

19 (a) Filed Feb 19 1945 (Date Received) Wm. Williams, M.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1945, at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 13 1944, to Feb. 17 1945, and that I last saw her alive on Feb. 16 1945.

Immediate cause of death	Duration
Cardio-Resp. failure	
Due to Hypertensive cardiovascular disease	
Due to	
Other Conditions Rheumatic heart disease	
Intertrochanteric fracture of hip. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 12/2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence December 13 1944 M
(c) Where did injury occur? 3206 Guilford Ave Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At home While at work? No
(Specify type of place)
(e) Means of injury Fell to floor in basement
23. Signature Frank C. Morgan, M.D.
Address U.M.H. Date signed 2-18-45
M. D.

VS 150

Approved: Robert Lee Graham M.D. × Feb. 18 1945

G26040 — BALTIMORE CITY HEALTH DEPARTMENT — G26040 Registered No.

CERTIFICATE OF DEATH 192a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 3534 Horton St (If rural give location)
(e) Citizen of foreign country? S. (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey R. Hoover

3 (b) If veteran, name war

3 (c) Social Security Account No. 236-36-2165

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Mary [illegible] Hoover

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1903

8. AGE: Years 40 | Months | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name George M. Hoover
13. Birthplace W. Va.

MOTHER
14. Maiden Name Lou Ella Simmons
15. Birthplace W. Va.

16 (a) Informant Mary Hoover
(b) Address 3534 Horton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/45 (month) (day) (year)
(c) Cemetery or crematory
Location Keyser W. Va.

18 (a) Funeral director Martin J. Conroy
(b) Address 1102 Forest St.

19 (a) FEB 19 1945 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1945, at 12 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Calcific Aortic Stenosis

Due to Congenital Bicuspid Aortic Valve.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Feb. 19 1945

VS 151

(OVER)

626041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

626041 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2342 E Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lazarus Book

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-6154

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb, 18, 1895

8. AGE: Years	Months	Days	If less than one day
50		1	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business Clerk

FATHER
12. Name Jacob BooK
13. Birthplace Russia

MOTHER
14. Maiden Name Minnie Rubin
15. Birthplace Russia

16 (a) Informant Louis Book
(b) Address 2342 E Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 20, 1945 (month) (day) (year)
(c) Cemetery or crematory Anshei Emunah Cong Cem
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124- 1126 W North Ave

19 Filed FEB 20 1945 (Date filed by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19/45 19 at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/19 1945 to 2/19 1945, and that I last saw h-- alive on 2/19 1945.

Immediate cause of death Myocardial insufficiency — Duration

Due to Coronary occlusion

Due to Arterio sclerotic h. dis

Other Conditions Fibro caseous tuberc apical TB & cavity formation (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Coronary occlusion

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Aronson M. D.
Address Sinai Hosp Date signed 2/19/45

944

6260424 ✓ 6260424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46M

Registered No. 6260424

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 W North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 W North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Finkelstein

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-18-6851

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rebecca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1892

8. AGE: Years	Months	Days	If less than one day
52	11	28	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business Shipping Clerk

FATHER
12. Name Jerome Finkelstein
13. Birthplace Poland

MOTHER
14. Maiden Name Pearl ?
15. Birthplace Poland

16 (a) Informant Rebecca Finkelstein
(b) Address 711 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 21/45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave
18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave
19 (a) FEB 20 1945 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION 8.30

20. DATE OF DEATH February 18 1945, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3rd 1944 to Feb 18 1945 and that I last saw h[illegible] alive on 2/18 1945.

Immediate cause of death Carcinoma of the whole digestive tract — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Maurice Shucket M. D.
Address 2775 Tenn Date signed 2/19/45

VS 150

Spec.—8-16-29—L. F. S.—100 Blks.

626043

HEALTH DEPARTMENT—CITY OF BALTIMORE

626043

CERTIFICATE OF DEATH

97

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 12 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia A. Moffett

(a) RESIDENCE NO. 314 E. 21st St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

6a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Chas. A. Moffett

6 DATE OF BIRTH (month, day, and year): Nov. 21, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	84	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Burkittsville

(State or country) Frederick, Maryland

PARENTS

10 NAME OF FATHER: Jerry M. Horner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Fred. Co., Md

12 MAIDEN NAME OF MOTHER: Mary Hightman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Fred. Co. Md.

14 Informant: Ray R. Moffett

(Address) 314 E. 21st St, City

15 Filed FEB 20 1945 Huntington Williams, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 19-45

17

I HEREBY CERTIFY, That I attended deceased from October, 1944, to Feb 19, 1945

that I last saw h. alive on Feb 18, 1945

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

uremia

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Jack J. Singer, M. D.

, 19 (Address) 506 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery, Frederick, Md

DATE OF BURIAL: 2/21/1945

20 UNDERTAKER: M. R. Etchison & Son

ADDRESS: Frederick Md

Important. See instructions on back of certificates. Exact statement of OCCUPATION is very necessary as it is by occupations that the nature of many diseases is properly classified.

G26044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G26044

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3341 Windsor Ave
(c) Hospital or institution:

15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3341 Windsor Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Kitty Blanche Ulrich,

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Jacob K.Ulrich,
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) July 16.1886

8. AGE: Years 58 | Months 7 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Carroll Co.Md.
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Leander Babylon,
13. Birthplace Carroll Co.Md.

MOTHER
14. Maiden Name Susan K.Fleagle
15. Birthplace Carroll Co.Md.

16 (a) Informant Jacob K.Ulrich,
(b) Address 3341 Windsor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb.21.1945 (month) (day) (year)
(c) Cemetery or crematory Church of The Brethern
Location Carroll Co.Md.

18 (a) Funeral director George W.Little,
(b) Address 2700 Edmondson Ave.

19 (a) FEB 20 1945 (Date received by Registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 18 1945 at 7 45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 1942 to 2/18 1945, and that I last saw h[illegible] alive on 2/18 1945.

	Duration
Immediate cause of death: Coronary occlusion	4 days,
Due to: Myocardial insufficiency	3 days
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert A. Reale M.D.
Address 340 S Windsor Ave Date signed 2/19/45

VS 150

646045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4 P A

Registered No. 646045

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dorchester & Raymond Ave
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 N. Wordington Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Griffith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Arthur E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6-1880

8. AGE: Years	Months	Days	If less than one day
64	5	12	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John Louis
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Fittle
15. Birthplace Hanover Pa.

16 (a) Informant Arthur E. Griffith Jr.
(b) Address 7 N. Wordington Rd

17 (a) Burial (b) Date thereof Feb-22-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem.
Location Lyons Falls, on

18 (a) Funeral director Thos. J. Moran
(b) Address 1201 Fremont Ave

19 (a) Filed FEB 20 1945 (b) Investigation by Williams, M.D.
(Date filed by registrar) Registrar

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1945, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1945, to Feb 18 1945, and that I last saw her alive on Feb 18 1945.

Immediate cause of death Pneumonia - bronchopneumonia acute with pulmonary edema — Duration

Due to Congestive heart failure

Due to Lobar pneumonia - bilateral

Due to

Other Conditions Carcinomatosis Pleurisy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ruth W Baldwin M. D.

Address West Baltimore Gen. Hosp. Date signed 2/19/45

108

626046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 626046

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Jos. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 N. POTOMAC ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ANDREO KOVALICK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1894

8. AGE: Years	Months	Days	If less than one day
50	4		hr. min.

9. Birthplace Czechoslovakia (Town, City, and State)
10. Usual Occupation Pipe Cutter
11. Industry or business

FATHER 12. Name Cyprian Kovalick
13. Birthplace Czechoslovakia

MOTHER 14. Maiden Name Dont. Know
15. Birthplace "

16 (a) Informant Anna Kovalick
(b) Address 519 N. Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 21 - 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John A. Wagner
(b) Address 300 E. Baltimore St

19 FEB 20 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1945, at 5.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1945 to Feb 17 1945 and that I last saw him alive on Feb 17 1945

Immediate cause of death	Duration
ACUTE DILATATION OF HEART	
Due to BILAT. FULMINATING PNEUMONIA	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bauer
Address 801 E. Lanvale St. Date signed M. 2 D. 17/45

VS 150

M Phillips

G66047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

930

Registered No. G66047

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2905 Riggs Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2905 Riggs Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice M Braun (BRAUN)

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George L Braun

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22. 1853

8. AGE: Years 91 | Months 6 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore MD
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Isaac Kelley
13. Birthplace MD

MOTHER
14. Maiden Name Emily Cloudy (CLARIDGE)
15. Birthplace MD

16 (a) Informant Emilie Braun
(b) Address 2905 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/45 (month) (day) (year)

(c) Cemetery or crematory Western
Location Baltimore MD

18 (a) Funeral director Fulton & Cook Co
(b) Address 129 E Pratt St

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1945, at 4 A M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945, to Feb 19 1945, and that I last saw h[illegible] alive on Feb 19. 1945.

Immediate cause of death	Duration
Acute myocarditis	
Due to Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jno. H Phillips M. D.

Address 1939 Edmondson Date signed 2-20-45

X

G26040 ✓ G26040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3600 Cottage Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lattin, Harry

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Sarah
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1877
8. AGE: Years 68 Months Days If less than one day hr. min.
9. Birthplace: Russia (Town, county, and state)
10. Usual Occupation: none
11. Industry or business

FATHER
12. Name: Nathan
13. Birthplace: Russia

MOTHER
14. Maiden Name: Tova
15. Birthplace: Russia

16 (a) Informant: Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnel & Ft
18 (a) Funeral director Jos. C. Lemmelein
(b) Address 1439 E Balto St.
19 (a) Date received by local Registrar FEB 20 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19 1945, at 2.25 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 2-17 1945, to 2-19 1945, and that I last saw him alive on 2-19 1945.

Immediate cause of death: Myocardial failure — Duration
Due to: Arteriosclerotic Cardio-vascular disease
Due to:
Other Conditions: Missing pleural effusion on Rt
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome Richard Harkin M. D.
Address Sinai Hospital Date signed 2-(9-45

X

G26043 BALTIMORE CITY HEALTH DEPARTMENT G26043

CERTIFICATE OF DEATH 146 (Registered No.)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument St
(c) Hospital or institution: Sinai Hospt 151
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 Orealbury St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rae Jeanne Cohen (RAJEGNNE COHEN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Nathan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years	Months	Days	If less than one day
32			hr. min.

9. Birthplace DE MOINES IOWA
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace U.S.A.

MOTHER
14. Maiden Name Not Known
15. Birthplace U.S.A.

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (b) Date thereof 2-20-45
(Burial, cremation, or removal) (month) (day), (year)
(c) Cemetery or crematory Balto Hebrew
Location Belair Rd.

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D.

FEB 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18 1945, at 5:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17 1945, to 2/18 1945, and that I last saw h[illegible] alive on 2/18 1945.

Immediate cause of death	Duration
Shock	
Due to Transfusion Reaction	
& Massive hemorrhages	
Due to Incarcerated Blood Uterus	
Other Conditions Post-Partum Hemorrhage, Delayed	

(Include pregnancy within 3 months of death)

Date of operation 2/18/45

Major findings of operation: Retained Membranes, Torn Uterus, Hem

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Raymond B. Goldberg M. D.
Address Sinai Hosp. Date signed 2/18/45

G26050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931D

G26050 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution Sinai Hospt 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 E. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Berman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Daniel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 65 Months Days If less than one day hr. min.

9. Birthplace ~~Russia~~ Russia
(Town, county, and state)

10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Benj. Meyer
13. Birthplace Russia

MOTHER
14. Maiden Name Mollie Jetty
15. Birthplace Russia

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Dorsey Rd

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) Date received by local registrar FEB 20 1945 (b) Signature of local registrar William [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19 1945, at 11 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1945 to 2/19 1945, and that I last saw her alive on 2/19 1945.

Immediate cause of death: Cardio Resp Failure — Duration
Due to: Coronary Thrombosis
Due to: ASHD
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Simon M. D.
Address Sinai Hospital Date signed 2/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626051

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a Registered No. [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2123 E. Pratt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt (If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 E. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Bernstein

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Helda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Upholster
11. Industry or business

FATHER
12. Name Aaron
13. Birthplace Russia

MOTHER
14. Maiden Name Rebeca
15. Birthplace Russia

16 (a) Informant Helda Bernstein
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Pennsylvania Ave & Carroll St

18 (a) Funeral director Jack Levy Inc
(b) Address 1439 E. Balto St

19 (a) FEB 20 1945 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20-45 19 , at 5 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1945, to Feb 20 1945, and that I last saw him alive on Feb 19 1945.

Immediate cause of death Acute Pulmonary Oedema
Due to Acute Coronary Thrombosis
Due to
Other Conditions La Grippe
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 3 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Brill M. D.
Address 826 N. Washington St. Date signed Feb. 20 1945

VS 150

G66052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 2 ✓ Registered No. G66052

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1835 N Montford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 - V
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No 1835 N Montford Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Schulze

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, ~~married~~, widowed, or ~~divorced~~
Female	White	Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29th 1865

8. AGE: Years	Months	Days	If less than one day
79	4	18	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name —
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs E. Raley
(b) Address 1835 N Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20th 1945 (month) (day) (year)
(c) Cemetery or crematory Balto
Location E Northy Ave Ext

18 (a) Funeral director Leo F. Cook
(b) Address 1701-03 N Patterson Park Ave

19 (a) (b) Registrar

FEB 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17th 1945, at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 4, 1944 to Feb 17, 1945, and that I last saw h[illegible] alive on Feb. 15 1945.

Immediate cause of death	Duration
Coronary Thrombosis	4 Hrs
Due to Arteriosclerosis	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert E Singewald M.D.
Address 613 E. North Ave Date signed 7-9-45

626053 ✓ 626053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 186a

Every item of information should be carefully supplied. Please write plainly, with UNFADING INK. Every item should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 N. Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo Watts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years	Months	Days	If less than one day
38			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name George Watts
13. Birthplace Md

MOTHER
14. Maiden Name Mary Waters
15. Birthplace Md

16 (a) Informant William Watts
(b) Address 511 N Carrollton ave

17 (a) Burial (b) Date thereof 2-21-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md

18 (a) Funeral director Mrs Frances A Hensley
(b) Address 516 N Bidale St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

FEB 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1945, at 1 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Sub dural
Hematoma, Left

Due to

Other Conditions History of epilepsy
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 11/3 30

(a) Date of injury Feb. 15th 1945 12 ? M.
(b) Where did injury occur? Richard Mantuit, Harvard St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Probably fell to pavement

23. Signature Robert A. Graham M.D.
Medical Examiner.
Date signed Feb 15 1945

G26054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

482 Registered No. G26054

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1521 Retreat St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1521 Retreat St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa L. White

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-22-8015

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Alfred C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1883

8. AGE: Years 61 | Months 5 | Days 8 | If less than one day hr. min.

9. Birthplace Plymouth, N. C. (Town, county, and state)

10. Usual Occupation Maid

11. Industry or business

FATHER
12. Name Melvin Sherrod
13. Birthplace Plymouth, N. C.

MOTHER
14. Maiden Name Jane Close
15. Birthplace Hamilton, N. C.

16 (a) Informant Milvyn Reddick
(b) Address 421 Evans Chapel Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24 1945 (month) (day) (year)

(c) Cemetery or crematory Arbutus
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Sam. A. Hall
(b) Address 1631 Druid Hill Ave.

19 (a) FEB 20 1945 (Registered by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1945, at 11:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1944 to Feb 16 1945 and that I last saw h alive on Feb 16 1945

Immediate cause of death	Duration
Pneumonia	One month
Due to Carcinoma of Breast	3 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Bradman Tyler M. D.
Address 2743 Madison Ave Date signed 2-19-45

VS 150

626055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 626055

58 C

Registered No.

Every item of information should be carefully answered. Where DYEING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dot
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Millersville, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Elevation Station
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GRACE CHARLOTTE DILLOW

3 (b) If veteran, name war	3 (c) Social Security Account No.
**	**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1929

8. AGE: Years	Months	Days	If less than one day
15	1	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Howard M. Dillow
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Margaret M. Hatton
15. Birthplace Balto., Md.

16 (a) Informant Mr. Howard M. Dillow
(b) Address Elevation Station, Millersville Md.

17 (a) Burial (b) Date thereof 2/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 20 1945
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18 1945, at 11:30 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rheumatic C.V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Clinton J. Pudritz M.D.
Medical Examiner.
Date signed 2/19/45

X

626056 ✓ 626056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 612 Reservoir St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Reservoir St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADELAIDE B. OWENS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Henry Drury Owens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1883

8. AGE: Years	Months	Days	If less than one day
61	8	2	hr. min.

9. Birthplace Calvert Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John James Brooke Bond
13. Birthplace Calvert Co., Md.

MOTHER
14. Maiden Name Elizabeth Tongue
15. Birthplace A. A. Co., Md.

16 (a) Informant Mr. Henry D. Owens
(b) Address 612 Reservoir St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director W. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 20 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19, 1945, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1944 to Feb 19 1945 and that I last saw h alive on Feb 10 1945

Immediate cause of death	Duration
Pulmonary Carcinoma	6 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm A Pearce M. D.
Address 215 St Paul St Date signed Feb 20/45

VS 150

626057 ✓ ✗ 47D 626057

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So. Balto Gen Hosp
Has had first
(d) Length of stay in hospital or inst. (yrs., mos., or days) different hospital admittance
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A.A.
(c) City or town Brooklyn P. O.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4701 Ballmon Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura G. Gischel

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh	Widow

6 (b) Name of husband or wife William George Gischel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1869

8. AGE: Years	Months	Days	If less than one day
76	0	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Fred Ballman
13. Birthplace Germany

MOTHER
14. Maiden Name Annie Catherine Schultz
15. Birthplace Germany

16 (a) Informant Mrs. John Obrecht, Jr.
(b) Address 4701 Ballman Ave.

17 (a) Burial (b) Date thereof 2/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) FEB 20 1945 (b) [illegible]
(Date rec'd by registrar) Registrar

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19 45, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19. Pt had 4 hospital admissions

Immediate cause of death	Duration
Carcinoma of lung	
Due to	
Due to	
Other Conditions Heart failure. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. D. Gassaway M. D.
Address So. Balto Gen Hosp Date signed 2/19/45

626058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

626058 Registered No. 13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 407 N.Glover St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 407 N.Glover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M.George

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James S.George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.11,1906

8. AGE: Years	Months	Days	If less than one day
38	4	8	hr. min.

9. Birthplace Balto.Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Philip Schaeffer
13. Birthplace Balto.Md.

MOTHER
14. Maiden Name Anna Horstschneider
15. Birthplace Balto.Md.

16 (a) Informant Mr.James S.George
(b) Address 407 N.Glover St.

17 (a) Burial (b) Date thereof Feb.22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Balto.Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) Date received by Local Registrar FEB 26 1945 Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19/45, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/43 19 to 2/19/45, and that I last saw h-r alive on 2/17/45.

Immediate cause of death	Duration
T Phthis Pulmonalis	
Due to Infection	
Due to T B Ulcer (Left Lung)	
Other Conditions none	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. H. Hemman M. D.
Address 1710 E 33rd Date signed 2/20/45

VS 150

626053 626053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 131 McMechen ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 131 McMechen ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James W Connolly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W.

6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/14/1873

8. AGE: Years 71 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Frederick Co Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alexander Connolly
13. Birthplace Ireland

MOTHER
14. Maiden Name Cath. R. Feasey
15. Birthplace Walkersville, Md

16 (a) Informant Mrs. Mabel Bonnell
(b) Address 605 Magnolia - Frdk. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/45 (month) (day) (year)
(c) Cemetery or crematory Lovely Hill
Location Lovely Md

18 (a) Funeral director The N C Dilsheimer Co
(b) Address Laurel Md

19 (a) FEB 20 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1945, at 6 50 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner.)
Date signed Feb 18 1945

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1603

Registered No. G66060

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Jerome Bernard Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-5-45

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Milford Johnson
13. Birthplace Clinton S.C.

MOTHER
14. Maiden Name Daisy Chapman
15. Birthplace Greenville S.C.

16 (a) Informant Daisy Johnson
(b) Address 620 W. Saratoga St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) FEB 20 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10-1945 at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 1945 to 2-10 1942, and that I last saw him alive on 2-10-1945.

Immediate cause of death	Duration
Hemorrhage	
Due to Collapse	
Due to Gradated Cancer Hemorrhage	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. Louis Jones M. D.
Address 1100 Druid Hill Ave Date signed 2/15/45

VS 150

Kept for Anatomical Purposes. X

G26061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

G26061 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. o a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1426 Harris Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Gamble

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years 38 | Months | Days | If less than one day hr. min.

9. Birthplace Farmville, Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Hopkins Gamble

13. Birthplace Va

MOTHER 14. Maiden Name Rose Jeffries

15. Birthplace Va

16 (a) Informant Rose Jeffries

(b) Address Farmville Va

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 2-21-45 (month) (day) (year)

(c) Cemetery or crematory Farmville

Location Virginia

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E. Preston St

19 (a) FEB 20 1945 (Date rec'd by registrar) (b) Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION 45

20. DATE OF DEATH February 15, 1945, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed Feb 15 1945

VS 151

G26062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 42D

G26062

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the cau e causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2107 E. North Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME ANNA SCHAAF

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-3-79

8. AGE: Years 65 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Frederick Burkert

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Willinger

MOTHER 15. Birthplace Germany

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-45 (month) (day) (year)

(c) Cemetery or crematory Immanuel Cem

Location Hamilton Ave

18 (a) Funeral director John C Miller Inc

(b) Address 2425 E Oliver St

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 20 1945 Huntington Hathaway

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1945 at 5:34 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1945 to Feb 19 1945 and that I last saw h[illegible] alive on Feb 19 1945

	Duration
Immediate cause of death Respiratory Failure	
Due to Undiagnosed disease of Lungs	1yr.
Due to ? Carcinoma Lung	
Other Conditions ? Metastatic Ca Lung	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Abraham Cleeves M. D.

Address Johns Hopkins Hosp Date signed 2-19-45

G60063 BALTIMORE CITY HEALTH DEPARTMENT G60063
CERTIFICATE OF DEATH 10 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hanford Road
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 John Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Meekins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-2-38

8. AGE: Years	Months	Days	If less than one day
6	4	17	hr. min.

9. Birthplace Rock Hall Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Albert D. Meekins
13. Birthplace Chestertown, Md

MOTHER
14. Maiden Name Volare Thompson
15. Birthplace Rock Hall, Md

16 (a) Informant Mrs. Meekins
(b) Address 1603 John Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/45 (month) (day) (year)
(c) Cemetery or crematory Chester
Location Chesterlain, Maryland.

18 (a) Funeral director Maxie V. Williams
(b) Address Chesterlain, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 15 FEB 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19- 1945, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-17- 1945, to 2-19- 1945, and that I last saw him alive on 2-18 1945.

Immediate cause of death Diphtheria — Duration 8 days

With Extensive Impairment involvement of entire Tracheo-Bronchial Tree

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Myron B. Lee, M.D.
Address Sydenham Hosp. Date signed 2/19/45

X Jwl

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G26064 Registered No. 830

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 111 E. Churchill St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 111 E. Churchill St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Amelia Worthen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Wm. D. Worthen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1862

8. AGE: Years 82 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Frederick Mutta
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine
15. Birthplace

16 (a) Informant Mrs.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 21, 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director John F. Dennett, Inc.
(b) Address 715 Light St.

FEB 20 1945 (Date received by Registrar) Hattie Lee Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1945 to 2/18 1945, and that I last saw h alive on 2/18 1945.

Immediate cause of death — Cerebral Hemorrhage — Duration 5 days.

Due to — Arterial Hypertension — 2 mos

Due to Arteriosclerosis — 1 yr.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature O. B. Mebble M. D.
Address 1279 Hillsdale Date signed 2/19/45

VS 150

626065 over 626065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 926 Light St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 926 Light St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roland Henry Huebner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Alice Sypes

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1907

8. AGE: Years 39 70 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Jeweler.

11. Industry or business Self

FATHER
12. Name Hugo Huebner
13. Birthplace Germany

MOTHER
14. Maiden Name Sarah Anne Edwards
15. Birthplace Maryland

16 (a) Informant Mrs Selma Miller
(b) Address 3810 Annapolis Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Ave

18 (a) Funeral director John F Henny Inc
(b) Address 715 Light St.

19 (a) 2-20-1945 (b) Registrar
Date rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17th 1945 at 4 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Feb 17 1945 and that I last saw him alive on Feb 17 1945

Immediate cause of death	Duration
Malignant Hypertension	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Schofield Jr

Address 3501 Annapolis Rd Date signed 2/19/45

G26066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

F 3 D

G26066
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write information called for correctly supplied. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2231 Brunt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife Howard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
69	68		hr. min.

9. Birthplace Old Field, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Oliver Nichols
13. Birthplace Md

MOTHER
14. Maiden Name C. Henry
15. Birthplace Md

16 (a) Informant Jeremiah Young
(b) Address 2231 Brunt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. S. Kelson
(b) Address 1303 Pressman St

19 (a) FEB 20 1945 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1945, at 1 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebro vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb 19 1945

G26067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G26067 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1711 N. Carey St
(c) Hospital or institution:

15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 N. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Grant

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colored	Widowed

6 (b) Name of husband or wife John Grant
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31 1894

8. AGE: Years	Months	Days	If less than one day
50	6	17	hr. min.

9. Birthplace S. C.
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Larry Cook
13. Birthplace S. C.

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mary Speller
(b) Address 1711 N. Carey St

17 (a) Burial (b) Date thereof Feb 21, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Md
Location

18 (a) Funeral director George S. Wilson
(b) Address 1303 Pressman St

19 (a) (b)
(Date received by registrar) Registrar

FEB 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1945, at 11:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1944, to Feb 17 1944, and that I last saw her alive on Feb 16 1944

Immediate cause of death Carcinomatosis — Duration 1yr

Due to Metastatic Carcinomatosis Intestines & Lungs (Terminal)

Due to Carcinoma of Breast (Primary)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. S. Julian Jr. M. D.

Address 511 N. Schroeder St. Date signed 2/19/45

X

626068 BALTIMORE CITY HEALTH DEPARTMENT Registered No. 131a Catalina

CERTIFICATE OF DEATH

write the causes of death clearly and legibly. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Wheatroad St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 Wheatroad St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwina Campbell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 83 Months Days If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name Amanda
15. Birthplace

16 (a) Informant Sarah Johnson
(b) Address 1317 Wheatroad St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Presstman St

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 20 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18 1945 at 3.15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-vascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.

Date signed 2/18/45

G26063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G26063 Registered No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 446 Orchard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 446 Orchard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Halifax Co, Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name James G. Gravelle
13. Birthplace Halifax Co Va.

MOTHER 14. Maiden Name Ida Luster
15. Birthplace Va.

16 (a) Informant James Stovall
(b) Address 446 Orchard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date received by registrar) (b) Registrar

FEB 26 1945

VS 10

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18, 1945 at 6:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1945 to Feb. 18 1945 and that I last saw h im alive on Feb. 18 1945.

Immediate cause of death Cardio-Vascular Renal — Duration ?

Due to

Due to Arterio-sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward J. Mueller, M. D.
Address 1220 Druid Park Date signed Feb. 24/45

626070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

Registered No. 626070

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CALVERT STS.
(c) Hospital or institution: UNION MEMORIAL HOSPITAL. 2979
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mos 3 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 79 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE, 18.
(If outside city or town limits, write RURAL and give town)
(d) Street No. LOCH RAVEN BLVD & ARLINGTON AVE. PENTRIDGE APTS
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISE HEIMILLER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) APRIL 23, 1865

8. AGE: Years 79 | Months 9 | Days 26 | If less than one day — hr. — min.

9. Birthplace BALTIMORE, MARYLAND.
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business NONE

FATHER
12. Name CHRISTIAN HEIMILLER
13. Birthplace MARYLAND.

MOTHER
14. Maiden Name MINNA BISHON
15. Birthplace GERMANY

16 (a) Informant SISTER OF DECEASED. MRS. MONDERGER
(b) Address PENTRIDGE APTS. CITY 12.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21-45 (month) (day) (year)
(c) Cemetery or crematory David Ridge Cemetery
Location Pikesville Md.

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St

19 (a) (Date received by Registrar) (b) Registrar

FEB 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 18 1945 at 5:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19..., and that I last saw HER alive on Feb. 18 1945.

Immediate cause of death: CARDIO-RESP. FAILURE — Duration: 3 DAYS.

Due to ARTERIOSCLEROSIS — Duration: 7 YEARS

Due to — Duration:

Other Conditions FRACTURE OF RT. FEMUR. — Duration: 2 Mos 3 days

(Include pregnancy within 3 months of death)

Date of operation 12-18-44

Major findings of operation: FRACTURE OF NECK OF RT. FEMUR

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/9
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 12/17/44 at ? M
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fall

23. Signature William H. Lippitt M. D.
Address Union Memorial Hosp. Date signed 2/18/45

Dr. H. D. McNally by Howard Jr. Maddrix, M.D. X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V170

626071 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ Hospital
(c) Hospital or institution: Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6205 Harford Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Columbus Americus Davis

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Editha P. Davis
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Jan. 3-1869

8. AGE: Years 76 | Months 1 | Days 16 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William Davis
13. Birthplace Va.

MOTHER
14. Maiden Name Sallie Pettitt
15. Birthplace Va.

16 (a) Informant Mrs. Editha P. Davis
(b) Address 6205 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Rusk
(b) Address 6505 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

FEB 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19 1945 at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-8 1945 to 2-19 1945, and that I last saw him alive on 2-19 1945.

Immediate cause of death	Resp. failure	Duration
Due to	Pneumonia	
Due to	Cardiac decompensation	
Other Conditions		over

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Feb 2, 1945 at 8:15 P M
(c) Where did injury occur? Baltimore, Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? public (Specify type of place) While at work? No
(e) Means of injury Struck by auto

23. Signature J M Simmons M. D.
Address Univ. Hosp. Date signed 2-19-45

G26072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G26072 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 27th St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Dobson

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1872

8. AGE: Years 72 | Months July | Days 3 | If less than one day hr. min.

9. Birthplace Coffies Creek Va (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name James M Dobson
13. Birthplace Ga

MOTHER
14. Maiden Name Attie Hobby
15. Birthplace Ga

16 (a) Informant Robert M. Dobson
(b) Address 1716 Ashburton St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/20/45 (month) (day) (year)
(c) Cemetery or crematory Matthews Va
Location

18 (a) Funeral director Wm. J. Tuckner & Sons
(b) Address M & Pa ave.

19 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/20 1945, at 12:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/18 1945, to 2/20 1945, and that I last saw him alive on 2/20 1945.

	Duration
Immediate cause of death: Acute heart failure	
Due to: hypertension	
Due to: Coronary failure	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James J. Scott, M.D.
Address St. Joseph's Hosp. Date signed 2/20/45

VS 150

3
G26073

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1939

G26073 Registered No. L 4747

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 736 Greenmount Ave
(c) Hospital or institution:
—
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 736 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Alice D. Coles

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Augustus James Coles
(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Jan. 28, 1886
8. AGE: Years 59 | Months 0 | Days 21 | If less than one day hr. min.
9. Birthplace: Morrisville Va.
(Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Horace West
13. Birthplace: Va.

MOTHER
14. Maiden Name: Mary Sedden
15. Birthplace: Calvertor. Va.

16 (a) Informant: Minnie Coles
(b) Address: 736 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb 22, 1945 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary Cem.
Location: A A County Md.

18 (a) Funeral director: Mrs. Robert A. Elliott
(b) Address: 1297 N. Carolina Street

19 (a) Date filed by Registrar: FEB 23 1945 Huntingtor Williams, M. D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1945, at 1.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24 1945 to 2/17 1945, and that I last saw her alive on 2/17 1945.

Immediate cause of death: Cardiac Decompensation — Duration

Due to: Arteriosclerotic Heart Disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Ronald B. Lightstone Jr. M. D.
Address: 2129 Druid Hill Ave Date signed 2/17/45

X

3 G26074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G26074 Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1412 W Saratoga St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 W Saratoga St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Lena Jones Boley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Eugene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15 1877

8. AGE: Years	Months	Days	If less than one day
67	10	3	hr. min.

9. Birthplace Wicomico County Md.
(Town, county, and State)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Ennis Jones
13. Birthplace Md

MOTHER
14. Maiden Name Ellen Hitchens
15. Birthplace Md

16 (a) Informant Florence Boley Chester
(b) Address 1166 W Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21/45 (month) (day) (year)
(c) Cemetery or crematory Laurel Cemetery
Location

18 (a) Funeral director Mrs. Robert O. Edmonds
(b) Address 1129 N Carlton St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS. 150

FEB 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1945 at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Feb 18 1945, and that I last saw her alive on Feb 17 1945.

Immediate cause of death	Duration
Cardio - Renal	1
Due to	2 mo
Due to	18 da
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. D. Hatcher M.D.
Address 1275 Eutaw St Date signed 2-20 1945

3 G66075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G66075 Registered No.

write the causes of death clearly and legibly. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2041 Llewellyn Ave (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mary Miller (Young)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced? Married

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1907

8. AGE: Years 37 | Months 11 | Days 9 | If less than one day .....hr. .....min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Richard Miller
13. Birthplace Va

MOTHER
14. Maiden Name Mary Crawley
15. Birthplace Va

16 (a) Informant Elana Lemmel
(b) Address 1320 N. Dallas St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location A. A. County Md.

18 (a) Funeral director Mrs. Lorella E. Ellwood
(b) Address 1129 N. Caroline St.

19 (a) FEB 20 1945 (Date rec'd by registrar) (b)..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1945, at 12:30 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to 2nd degree burns

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb. 13 1945 8/7 M.
(b) Where did injury occur? 2041 Llewellyn Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? Yes
(d) Means of injury Clothes ignited by oil stove

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Feb 17 1945

VS 151

X

2G26075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1939 G 2611 D Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1628 Division Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 Division St.
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Julia E. Pye Watson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Walter Watson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1885

8. AGE: Years 59 | Months 3 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER
12. Name Edward W Pye
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Ferguson
15. Birthplace

16 (a) Informant Agnes W Patterson
(b) Address 2821 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 21/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Frederick Road

18 (a) Funeral director Mrs Robert A. Elliott Dyk
(b) Address 1129 N. Caroline St.

19 (a) FEB 20 1945 (Date rec'd by registrar) (b) Hattie Lee Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 1945, at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1936 to Feb. 11 1945 and that I last saw her alive on Feb. 11 1945.

Immediate cause of death Coronary Thrombosis — Duration ?

Due to Hypertensive heart disease — Duration ?

Due to Hypertension — Duration ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Walter Shennington M. D.
Address 201 N Carey St Date signed 2/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626077 [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

TN: [redacted] 2121

CERTIFICATE OF DEATH 1724

Registered No. 17

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 N. Fremont St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Valentine

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug, 5th, 1923
8. AGE: Years 21 | Months 6 | Days 15 | If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Frank Valentine
13. Birthplace Maryland

MOTHER
14. Maiden Name Elsie Thomas
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 718 Druid Hill Ave.

19 (a) FEB 20 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19th, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14, 1945 to Feb 19 1945 and that I last saw him alive on Feb 19 1945.

	Duration
Immediate cause of death: Cardio-respiratory failure	3 days
Due to ~~malignant tumor of lymphatic system~~, Pneumonia, and/or GENERALIZED MILIARY TUBERCULOSIS	4 months
Other Conditions lupus erythematosis (Include pregnancy within 3 months of death)	(over)

Date of operation
Major findings of operation:
of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto. City Hosp. Date signed 2/19/45

VS 150

B 26078 BALTIMORE CITY HEALTH DEPARTMENT G26078

CERTIFICATE OF DEATH 83a

Registered No. [redacted]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town.....
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2846 North Point Road
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3. FULL NAME Maud Alma Grantz Owens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband ~~or wife~~ Walter A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1892

8. AGE: Years 52 | Months 8 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William J. Gray
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Wiley
15. Birthplace Maryland

16 (a) Informant Walter A. Grantz
(b) Address 2846 North Pt. Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Geo. E. Talbert
(b) Address Fulton & Fayette Sts

1945 FEB 20 (Date rec'd by registrar) Signature of Registrar

MEDICAL CERTIFICATION 40

20. DATE OF DEATH February 19, 1945 at 7 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Sub-dural Hemorrhage

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 2-19-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

620079 BALTIMORE CITY HEALTH DEPARTMENT 620079 [redacted]

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1839 E. LAFAYETTE AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 81 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1839 E. LAFAYETTE AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ANDREW J. VELKER

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ANNIE VELKER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 19 1863

8. AGE: Years	Months	Days	If less than one day
81 82	3	0	hr. min.

9. Birthplace GERMANY
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant ANNIE VELKER (WIFE)
(b) Address 1839 E. LAFAYETTE AVE.

17 (a) BURIAL (b) Date thereof FEB. 21/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory PARK WOOD
Location TAYLOR AVE.

18 (a) Funeral director Selby - Zahn Co.
(b) Address 403 S. WOLFE ST.

19 FEB 20 1945 (b) [illegible] for Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 19 1945, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from FEB 2 1945 to FEB 19 1945, and that I last saw him alive on FEB 18 1945.

Immediate cause of death	Duration
Myocarditis	1 yr.
Due to	
Due to	
Other Conditions Cerebral Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jacob Fisher M. D.
Address 1823 N. Mad. St Date signed 2/19/45

X

626060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 937

626060 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County BALTIMORE
(c) City or town BROOKLANDVILLE (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Paul Wolf

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Margaret Sinnott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 15, 1862

8. AGE: Years 82 | Months 9 | Days 3 | If less than one day: hr. min.

9. Birthplace: Catonsville, Md. (Town, county, and state)
10. Usual Occupation: Florist - Domestic
11. Industry or business: Employee Mrs. George Brown

FATHER
12. Name: John Wolf
13. Birthplace: Germany

MOTHER
14. Maiden Name: Genevie ?
15. Birthplace: Germany

16 (a) Informant: Mrs. Irwin Rick (Daughter)
(b) Address: 1652 Normal Avenue, City 13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-45 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVENUE & BROADWAY

19 (a) (b) Huntington Williams Registrar
Filed by registrar FEB 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 1945, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 16 1945, to Feb. 18 1945, and that I last saw him alive on Feb. 18 1945.

	Duration
Immediate cause of death: Cardiorespiratory failure	
Due to: Terminal cardiac decompensation	
Due to: Arteriosclerotic heart disease	
Other Conditions: Hypertension	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J. Frank Supplee III, M. D.
Address: Union Memorial Hospital Date signed 2/15/45

X

626081

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

626081
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20da
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2854 Mayfield Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME OSCAR ALEXANDER BARTELL

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13, 1867

8. AGE: Years	Months	Days	If less than one day
78	1	6 7	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired Police Officer
11. Industry or business Police Department

FATHER
12. Name Christopher Bartell
13. Birthplace Germany

MOTHER
14. Maiden Name J. F. Fredericka Tatchenhorst.
15. Birthplace Germany

16 (a) Informant Oscar A. Bartell, Jr. (Son)
(b) Address 2854 Mayfield Avenue - 13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) FEB 26 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1945, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Feb 20 1945, and that I last saw him alive on Feb 20 1945.

Immediate cause of death	Duration
Coronary failure	
Due to Arteriosclerotic C.V. disease	
Due to	
Other Conditions Arteriosclerotic gangrene	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. F. Haberkamp M. D.
Address Mercy Hosp Balto. Md. Date signed 2/20/45

VS 150

G26082 — BALTIMORE CITY HEALTH DEPARTMENT — G26082 Registered No.

CERTIFICATE OF DEATH 183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D.O.A. - Fort McHenry
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County
(c) City or town Cleves (If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D #1 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ray W. Hunt (RAY W. HURST)

3 (b) If veteran, name war

3 (c) Social Security Account No. 488-24-3511

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29-1920

8. AGE: Years	Months	Days	If less than one day
25 24	0	19	hr. min.

9. Birthplace Logan, Missouri (Town, county, and state)

10. Usual Occupation S 1/c

11. Industry or business U.S. Coast Guard

FATHER — 12. Name Fred A. Hurst

13. Birthplace Missouri

MOTHER — 14. Maiden Name Opha D.

15. Birthplace Missouri

16 (a) Informant U.S.C.G.

(b) Address Captain of the Port

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 20-1945 (month) (day) (year)

(c) Cemetery or crematory Springfield

Location Missouri

18 (a) Funeral director Roff C. & B.M. Walter

(b) Address Park & Strickland Sts

19 (a) AUG 20 1945 (Date rec'd by registrar) (b) Thomas J. Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1945, at A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 2-17-45 at 1-1 A M. Anchorage Basin Canton

(b) Where did injury occur? Balto. City Harbor

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?

(d) Means of injury Fell from dock at Pier 3

23. Signature Howard J. Thiesler M.D. Medical Examiner.

Date signed 2-19-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G60083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1/31 G60083 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2044 E. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2044 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Elizabeth Walstrum

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed
6 (b) Name of husband ~~Samuel~~ Samuel Walstrum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/13/1881 ~~1879~~

8. AGE: Years ~~65~~ 63 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace Leeds Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name John Lynch
13. Birthplace Cecil Co. Md.

MOTHER
14. Maiden Name Ella
15. Birthplace

16 (a) Informant David Walstrum
(b) Address 2044 E. Hoffman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/45 (month) (day) (year)
(c) Cemetery or crematory Leeds Cemetery
Location Elkton Maryland

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) (b) Date received by registrar FEB 21 1945 Huntington Williams M.D.

BVS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19th 1945 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to Feb 19, 1945, and that I last saw h[er] alive on Feb 19 1945.

Immediate cause of death	Duration
ARTERIOSCLEROSIS	3 Yrs
Due to CHR. INT-NEPH	1½ Yrs
Due to	
Other Conditions ACUTE HEART FAILURE	1 DAY

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James F Kavanagh M.D.
Address 334 McCleery Dr Date signed 2-19-45 M. D.

(OVER)

G26084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G26084

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Patient

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Heathsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA SCOTT

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex F

5. Color or race W

6 (a) ~~Single~~, married, ~~widowed, or divorced~~. Married

6 (b) Name of husband or ~~wife~~ Travis L. Scott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19th 1882

8. AGE: Years 62 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace Heathsville Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER
12. Name Joseph Pearson
13. Birthplace Va

MOTHER
14. Maiden Name Emil Sayer
15. Birthplace Va

16 (a) Informant Harry W. Scott
(b) Address 3307 Cedarhurst Rd

17 (a) Removal (b) Date thereof 2/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Coan Church
Location Heathsville Va

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) FEB 21 1945 (b)
(Date rec'd by registrar) Registrar

Huntington Hollowell, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20 1945 at 10:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-9 1945 to 2-20 1945, and that I last saw her alive on 2-20 1945.

Immediate cause of death	Duration
Pulmonary edema & uremia	
Due to Hypertension & chronic nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R B Moment III M. D.
Address Univ. Hosp. Date signed 2/20/45

X

626085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

626085
Registered No. 1312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1806 N. COLLINGTON AVE.
(c) Hospital or institution:

8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 N. COLLINGTON AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILHELMINA STENGER

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife STEPHEN STENGER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 23 1863

8. AGE: Years	Months	Days	If less than one day
81	3	27	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name CHRISTOPHER SEHLHORST
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant GEORGE STENGER (SON)
(b) Address 232 N. PATTERSON PARK AVE.

17 (a) BURIAL (b) Date thereof FEB. 22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Quinn INC.
(b) Address 403 S. WOLFE ST.

19 (a) FEB 21 1945 Hunting for Baltimore, Md.
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 19 1945 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1941 to Feb 19 1945 and that I last saw her alive on Feb 15 1945.

Immediate cause of death	Duration
Cerebral hemorrhage right hemiplegia	2/14/45
Due to Hypertensive arterio sclerotic cardio-vascular renal disease	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen G Magruns M. D.
Address 1105 N. Gay St. Date signed

VS 150

X

G66086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G66086 Registered No.

write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 96
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 Mueller St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Fleckenstein

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: F

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: ADAM FLECKENSTEIN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): DEC. 24 1870

8. AGE: Years 74 | Months 1 | Days 26 | If less than one day hr. min.

9. Birthplace: WESTMINISTER MD.
(Town, county, and state)

10. Usual Occupation: HOUSE WIFE

11. Industry or business: AT HOME

FATHER
12. Name: CONSATINE DEMLING
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: CAROLINE PHIFFER
15. Birthplace: GERMANY

16 (a) Informant: ANNA SCHIRMAR (SISTER)
(b) Address: 505 N. CASTLE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 22/45 (month) (day) (year)
(c) Cemetery or crematory: HOLY REDEEMER
Location: BELAIR ROAD

18 (a) Funeral director: Lilly and Zeiler INC.
(b) Address: 403 S. WOLFE ST.

19 (a) FEB 21 1945 (Date rec'd by registrar) Huntington Wells Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1945, at 10 10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic
Cardiovascular-renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb 19 1945

X

087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X/13B

Registered No. 6-26087

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Washington, D.C. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4600 Fairfield Ave.
(If rural give location) Bethesda, Md.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion E. French

3 (b) If veteran, name war —

3 (c) Social Security Account No. 566-32-6749

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John E. French
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Jan. 1899

8. AGE: Years	Months	Days	If less than one day
46	1		hr. min.

9. Birthplace Florida
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Fred Feldkenstein
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace Md.

16 (a) Informant Mrs. Anna M. Millea
(b) Address 116 Witherspoon Rd.

17 (a) removal (b) Date thereof 2/21/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Virginia

18 (a) Funeral director W. W. E. Degnelis Sons
(b) Address 2000 Georgia Ave. N.W.
(c) FEB 21 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 19 1945 to Feb 20 1945, and that I last saw her alive on Feb 20 1945

Immediate cause of death	Duration
Pneumonia, Lobar	2 days
Left Coronary Occl.	
Due to	
Due to	
Other Conditions Pulmonary Hypertension, Right Ventricular Hypertrophy	5 yrs.
(Include pregnancy within 3 months of death)	

Date of operation Feb 19 1945
Major findings of operation: Thrombosis
of autopsy: as noted above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vernon H. Norwood M. D.
Address Church Home & Hospital Date signed 2-20-45

VS 150

108

G26088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G26088

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BELVEDERE + GREENSPRING AVE
(c) Hospital or institution: LEVINDALE
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. BELVEDERE + Greenspring Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anne Berman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W

6 (b) Name of husband or wife Isaac Berman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
78 60			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Mrs. Rose Berman
(b) Address 2111 Callow Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rinedale
Location

18 (a) Funeral director Jos Levin & Sons
(b) Address 1439 E. Balto St

19 (a) FEB 21 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21 1945, at 2.30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17 1941, to 2-21 1945, and that I last saw her alive on 2-21 1945.

Immediate cause of death	Duration
Hypertension Arteriosclerosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Edmund Levin

Address Levindale Date signed 2/21/45

VS 150

468072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 626089

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2217 E. Fayette St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Luckman.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Jacob Luckman

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2. 2. 1857.

8. AGE: Years	Months	Days	If less than one day
58 57			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name 2. 2.
13. Birthplace 2. Russia

MOTHER
14. Maiden Name 2. 2.
15. Birthplace 2. Russia

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2-21-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friedale
Location

18 (a) Funeral director Jos Levin Inc
(b) Address 1429 E. Baltimore St

19 (a) FEB 21 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1945, at 6.35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 29 1945, to Feb. 21 1945, and that I last saw him alive on Feb. 21 1945.

Immediate cause of death Respiratory failure
Due to Cardiac arrest
Due to Hypertensive and arteriosclerotic heart disease
Other Conditions Myocardial infarction
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
24 Signature William J. Dixon
Address Johns Hopkins Hospital Date signed 2/24/45

VS 150

626090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

626090 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 929 Hollins St
(c) Hospital or institution: ~

(d) Length of stay in hospital or inst. (yrs., mos., or days) ~
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 929 Hollins St
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME George M. Burruss

3 (b) If veteran, name war	3 (c) Social Security Account No.
~	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife ~
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feby 7th 1883

8. AGE: Years	Months	Days	If less than one day
62		13	..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Inspector
11. Industry or business Water Dept. Balto City

FATHER
12. Name Henry L. Burruss
13. Birthplace England

MOTHER
14. Maiden Name Randals Peterson
15. Birthplace England

16 (a) Informant Mrs Mary C. Burruss
(b) Address 929 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location 3801 Frederick Ave

18 (a) Funeral director John C. Cowan & Son
(b) Address 901-03 Hollins St

19 (a) ..... (b) FEB 21 1945 Registrar
(Date received by registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 20th 1945, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1, 1944 to Feb. 20 1945; and that I last saw h[illegible] alive on Feb 20, 1945.

Immediate cause of death	Duration
Due to Chr. Myocarditis	several years
Due to Arthritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Herbert C. Blake M. D.
Address Med. Arts Bldg. Date signed .....

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

Registered No. G26091

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 913 St. Barnabas Ct. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Bessie May Essex Goode

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) OCT. 18, 1941

8. AGE: Years	Months	Days	If less than one day
3	4	—	..... hr. ..... min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name JOSEPH GOODE
13. Birthplace BALTIMORE MD.

MOTHER
14. Maiden Name ANNA M. ESSEX
15. Birthplace BALTIMORE MD.

16 (a) Informant MARY KNOX
(b) Address 516 FORREST STREET

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary cem-
Location A.A. County

18 (a) Funeral director BYRON WRIGHT
(b) Address 721 Argyle St.

19 (a) FEB 21 1945 (Date rec'd by registrar) (b) Interment for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18/45, at 11.20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to accidental death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock
2nd 3rd + 4th degree burns of
Legs, Thighs abdomen, back, chest
Due to and Head. Arms.

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/18/45 at 11.20 A.M. 17/1
(b) Where did injury occur? 913 St. Barnabas Ct.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury House on fire

23. Signature Hugh B. McNally M.D. Medical Examiner.
Date signed 2/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1/31 a

G26092 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2564 Wilkins Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days) 80 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2562 Wilkins Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Maria Schlaupner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Louis Schlaupner

6 (c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.) March 6-1854

8. AGE: Years 90 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name John Hemann

13. Birthplace Germany

MOTHER 14. Maiden Name —

15. Birthplace Germany

16 (a) Informant Wm. H. Schlaupner

(b) Address 2564 Wilkins Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/45 (month) (day) (year)

(c) Cemetery or crematory Western

Location Baltimore

18 (a) Funeral director J. A. Wappat & Son

(b) Address 316 Eutaw Place

19 (a) FEB 21 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19th 1945 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Feb 19 1945 and that I last saw h[illegible] alive on Feb 19 1945.

Immediate cause of death Asthenia Duration

Due to Chronic Interstitial Nephritis

Due to Myocarditis - Senility

Other Conditions Pulmonary Oedema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Richard G. Peters M. D.

Address 2151 Wilkins Ave Date signed 2/20/45

Huntington Williams, M.D. Registrar

VS 150

G26093 G26093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945 E

Registered No.

Write plainly with pen or pencil. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 325 S. Newkirk St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David John Griffiths

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married.

6 (b) Name of husband or wife Marie A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15-1892

8. AGE: Years	Months	Days	If less than one day
52	2	5	hr. min.

9. Birthplace Wales (Town, county, and state)

10. Usual Occupation Bethlehem Steel Co.

11. Industry or business Oiler

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Marie A. Griffiths

(b) Address 325 S. Newkirk St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-45 (month) (day) (year)

(c) Cemetery or crematory Moreland

Location Baltimore

18 (a) Funeral director Leonard J. Rucker

(b) Address 5305 Harford Rd

19 (a) FEB 21 1945 (Date received by registrar) Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1945, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowned

Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Feb. 20 1945 at 25/6 M.

(b) Where did injury occur? Bethlehem-Fairfield

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes

(d) Means of injury Explosion

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed Feb 20 1945

M. D. B. 1208-B

HEALTH DEPARTMENT—CITY OF BALTIMORE

626094 CERTIFICATE OF DEATH 108 626094

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Hopewell Ct St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. 6 ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Willie Lee Laster

(a) Residence: No. 1424 Hopewell Ct St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Clarice Laster

6. DATE OF BIRTH (month, day, year) Mar 4, 1906

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	11	15	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Fairfield Shipyard

10. Date deceased last worked at this occupation (month and year) Feb 19 1945

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) S. Hampton Co., Va. Va.

FATHER

13. NAME Unobtainable

14. BIRTHPLACE (city or town) (State or country) Unobtainable

MOTHER

15. MAIDEN NAME K. Miller

16. BIRTHPLACE (city or town) (State or country) North Carolina

17. INFORMANT Clarice Laster

(Address) 1424 Hopewell Ct

18. BURIAL, CREMATION, OR REMOVAL

Place Hollywood Va Date 2/22 1945

19. UNDERTAKER Geo. D. Kelson

(Address) 303 Eastman St

20. FILED FEB 21 1945 Clinton Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb. 19, 1945

22. I HEREBY CERTIFY, That I attended deceased from Feb 14, 1945 to Feb 19, 1945

I last saw h[illegible] alive on Feb 19, 1945 Death is said to have occurred on the date stated above, at 5.10 P.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	1 wk

Other contributory causes of importance:

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) McDonald Bendo, M. D.

(Address) 24 [illegible] Dr. Hill Ave., Phila. 17

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. 8

1CT 626095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

626095 / 31a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 Shields Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 5-5-yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 Shields Place (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Tasker Gross

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Fem.

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Calvert Co., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph ?
13. Birthplace Calvert Co., Md

MOTHER
14. Maiden Name Margaut ?
15. Birthplace Calvert Co., Md.

16 (a) Informant Estelle Lee
(b) Address 920 Shields Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. A. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

FEB 21 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19- 1945 at 11:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31- 1945 to 2-19- 1945 and that I last saw h. alive on 2-17- 1945

Immediate cause of death: Cardio-renal-Vascular disease — Duration: 3 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. T. Page, M.D.
Address 1516 N. Mount St. (17) Date signed 2-21-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

626096 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2712 Fox St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2712 Fox St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Son Haskins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Carrie Haskins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14-1890

8. AGE: Years	Months	Days	If less than one day
54	10	5	hr. min.

9. Birthplace Charlotte Va (Town, county, and state)
10. Usual Occupation
11. Industry or business Contractor

FATHER
12. Name Alexander Haskins
13. Birthplace Va

MOTHER
14. Maiden Name Elizabeth Hall
15. Birthplace Va

16 (a) Informant Carrie Haskins
(b) Address 2712 Fox St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-45 (month) (day) (year)
(c) Cemetery or crematory Drake Branch Va
Location Charlotte Co. Va

18 (a) Funeral director Wm Francis A Hemsley
(b) Address 578 Robbidle St

19 (a) (Date rec'd by registrar) (b) 1945 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1945, at 7:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1944 to Feb 19 1945, and that I last saw h[illegible] alive on Feb 19 1945.

Immediate cause of death	Duration
Carcinoma of Lung	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W Eustace M. D.
Address 805 N Fremont Ave Date signed

X

626097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

626097 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2645 N. Charles St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2645 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME IRMA WEISBERGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1899.

8. AGE: Years	Months	Days	If less than one day
45	6	1	hr. min.

9. Birthplace Austria.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Solomon Weisberger,
13. Birthplace Austria.

MOTHER
14. Maiden Name Charlotte Langer,
15. Birthplace Austria.

16 (a) Informant Mr. Siegfried Weisberger,
(b) Address 2645 N. Charles St.

17 (a) Burial (b) Date thereof 2/ /45.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director David Sonnenborn & Son
(b) Address 1902 Eutaw Place

19 FEB 21 1945 (b) Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19th. 1945 at PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1945, to Feb. 16 1945, and that I last saw her alive on Feb 16 1945.

Immediate cause of death	Duration
Coronary occlusion	
Due to Hypertensive cardio-vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charlotte McCarthy M. D.
Address Medical Arts Bldg Date signed 2/20/45.

X

G26098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G26098

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4102 Roland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4102 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM HUTCHESON

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Emma B. Hutcheson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1859

8. AGE: Years	Months	Days	If less than one day
86	0	24	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Retired Mfct.
11. Industry or business

FATHER
12. Name David W. Hutcheson
13. Birthplace Scotland

MOTHER
14. Maiden Name Esther B. Culbard
15. Birthplace Scotland

16 (a) Informant Mr. Culbard R. Hutcheson
(b) Address 4102 Roland Ave. 11

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/45 (month) (day) (year)
(c) Cemetery or crematory Jessop's Meth. Ch. Cem.
Location Cookeysville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 21 1945 (b) Huntington Ave. Baltimore, Md.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19, 1945 at 7:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to Feb 19 1945.
and that I last saw h alive on Feb 19 1945.

Immediate cause of death	Duration
a Pneumonia	2 4 hrs.
Due to Cerebral Hemorrhage	7 days
Due to Arteriosclerosis	8 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Thompson M.D.
Address 313 Edgevale Rd Date signed 2/20/45

G26099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 129

Registered No. G26099

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County Pr. Georges
(c) City or town Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. 132 Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Angeline Tellema

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Lyman D. Tellema
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-23-07

8. AGE: Years	Months	Days	If less than one day
37.	7	26	hr. min.

9. Birthplace Mich. (Town, county, and state)
10. Usual Occupation Postal Directory H. Made
11. Industry or business

FATHER
12. Name Herman Brummel
13. Birthplace Mich

MOTHER
14. Maiden Name Ann Meyering
15. Birthplace Mich

16 (a) Informant Relative
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 2/21/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory --
Location Grand Rapids, Mich.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 21 1945 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 19 1945, at 7.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan - 9 1945, to Feb-19 1945, and that I last saw him alive on Feb-19 1945.

Immediate cause of death	Shock	Duration
Due to	Generalized peritonitis	
Due to	Ulcerative colitis	
Other Conditions	Rheumatoid arthritis	

(Include pregnancy within 3 months of death)
Date of operation 2-19-45
Major findings of operation: Peritonitis, generalized.
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Whittington M. D.
Address J HK. Date signed 2-20

VS 150

G26100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 E

Registered No. G26100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1043½ W. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1043½ W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Mark Johnson.

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-9080.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Margaret Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Westmoreland Co., Virginia. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name John M. Johnson.
13. Birthplace Virginia.

MOTHER
14. Maiden Name Lydia
15. Birthplace Virginia

16 (a) Informant Mrs. Margaret Johnson.
(b) Address 1043½ W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

FEB 21 1945 Huntington Williams M.D.
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1945 to Feb 18 1945, and that I last saw h-- alive on Feb 15 1945.

Immediate cause of death: Uremia Nephritis acute — Duration 2 days
Due to Endocarditis — Duration 4 months
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John T. Thomas M. D.
Address 1521 Edmondson Ave Date signed

X

G26101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G26101

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 352, Stetson Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 140 9 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 E. 28th St. (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Glasco Devlin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/10/1866

8. AGE: Years 78 | Months 11 | Days 13 30 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name James Devlin
13. Birthplace England

MOTHER 14. Maiden Name Ellen Carroll
15. Birthplace England

16 (a) Informant Mrs J. F. Schott
(b) Address 1630 E. 28th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/45 (month) (day) (year)
(c) Cemetery or crematory St Ignatius
Location Loch Raven Md.

18 (a) Funeral director J. J. Gahey & Sons
(b) Address 1218 Light St.

19 (a) Date rec'd by registrar FEB 21 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20 1945 at 5 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1945 to Feb 20 1945, and that I last saw her alive on Feb 19 1945

	Duration
Immediate cause of death: Broncho Pneumonia	2 d.
Due to: Cerebral Hemorrhage	14 d.
Due to: Arteriosclerosis Hypertension	14 d.
	14 d.
	14 d.
Other Conditions: Chr Interstitial Nephritis (Include pregnancy within 3 months of death)	

Date of operation No.
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. F. A. Stevens M. D.
Address 2878 Harford Rd Date signed 2-20 45

23a

626102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 42D

Registered No. 626102

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 816 S. Belnord Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto Md. (If outside city or town limits, write RURAL and give town)

(d) Street No. 816 S. Belnord Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John G. Wojcik

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-3199

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Pauline

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Jan 21 1899

8. AGE: Years 46 | Months | Days 28 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Shipyard

FATHER 12. Name George Wojcik

13. Birthplace Poland

MOTHER 14. Maiden Name Tagonica Cuha

15. Birthplace Poland

16 (a) Informant Pauline Wojcik

(b) Address 816 S. Belnord ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 2/23/45 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Dundalk Ave

18 (a) Funeral director Stephen J. Fialkowski

(b) Address 1000 S. Kenwood Ave

19 (a) FEB 21 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1945, at 4:42 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945, to Feb. 19 1945, and that I last saw him alive on Feb. 18, 1945.

Immediate cause of death	Duration
Coronary Thrombosis	10 dy
Due to	
Due to	
Other Conditions Chronic valvular heart disease Chronic Hypertension (Include pregnancy within three months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John J. George M. D.

Address 26 W Eastern Date signed

VS 150

Kopec

26103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G26103 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1253 S. Decker Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3042 Boston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Kopec

3 (b) If veteran, name war

3 (c) Social Security Account No. 2-13-01-3821

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Johns

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 26-1876

8. AGE: Years 68 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER 12. Name Joseph WITEK

13. Birthplace Poland

MOTHER 14. Maiden Name Julia WITEK

15. Birthplace Poland Sliwinski

16 (a) Informant Mrs. Agnes Schmidt

(b) Address 1253 S. Decker Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 2-22-45 (month) (day) (year)

(c) Cemetery or crematory

Location St. Hedwigs Law County

18 (a) Funeral director Stephen J. Freihofer INC

(b) Address 1000 S. Kenwood Ave

19 (a) FEB 21 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1944 to Feb. 18 1945, and that I last saw h[er] alive on Feb. 17 1945.

Immediate cause of death Hypertension Cardio Vascular — Duration: days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Andrew Tomaszewski M. D.

Address 2579 Eastern Ave. Date signed

VS 180

Gentile

G26104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G26104 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 256 Exeter St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 256 N Exeter (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Gentile

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: m | 5. Color or race: w | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Grace Gentile
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Aug 6th 1878

8. AGE: Years 66 | Months 5 | Days 14 | If less than one day: hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Mario Gentile
13. Birthplace Italy

MOTHER 14. Maiden Name Filippa Nonita
15. Birthplace Italy

16 (a) Informant Mrs Ebby Nevaro
(b) Address 1622 McKewin Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 23-45 (month) (day) (year)
(c) Cemetery or crematory Mount Holly Recdmus
Location

18 (a) Funeral director Charles P Powell
(b) Address 3427 E Monument St

19 (a) (Date rec'd by registrar) FEB 21 1945 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1945, at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2, 1945, to Feb. 20, 1945, and that I last saw h im alive on Feb. 19, 1945.

Immediate cause of death	Duration
Congestive Heart Failure	5 hours
Due to Arteriosclerosis	Unknown
Myocarditis	Unknown
Due to Nephritis	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philibert Antignani M. D.
Address 2942 E. Fayette St. Date signed 2/20/45

X

2468-678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 13 D

Registered No. 626105

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 630 W. Rawlas St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Chester Williams

3 (b) If veteran, name war

3 (c) Social Security Account No. 21-14-5698

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male.	Black.	Married

6 (b) Name of husband or wife Inez.

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) 2-2-11

8. AGE: Years	Months	Days	If less than one day
34 yrs	—	13 14	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER
12. Name Wm. Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Ellis
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N Carrollton Ave.

19 (a) FEB 21 1945 (Date rec'd by registrar) Huntington Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb-16- 1945 at 4.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-9 1945 to Feb-16 1945 and that I last saw him alive on Feb-16 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Miliary tuberculosis	
Due to Of Lungs	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William T. Dixon M. D.
Address Johns Hopkins Hospital Date signed 2-16-45

VS 150

626106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

626106

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2652 Frederick Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Elkridge
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Marshall

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) ~~Single, married,~~ widowed, or ~~divorced~~ Widow

6 (b) Name of husband or wife Jas L. Marshall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 11-1861

8. AGE: Years 83 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Richmond Va
(Town, county, and state)

10. Usual Occupation Stove.

11. Industry or business

FATHER
12. Name John H Russell
13. Birthplace Va

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Jas L. Marshall
(b) Address 2004 Griffis Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 22 1945 (month) (day) (year)
(c) Cemetery or crematory Melvill Cem.
Location Elkridge Md.

18 (a) Funeral director L. Lester Gary
(b) Address 2503 Main St Elkridge

19 (a) FEB 21 1945 (Date rec'd by registrar) (b) Huntington Williams Md.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20th 1945 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1945 to Feb 19 1945 and that I last saw h[illegible] alive on Feb 19 1945

Immediate cause of death	Duration
Acute Cardiac Dilitation	One day
Due to Cardio-vascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Klussmann M. D.
Address 2687 Madison Ave Date signed Feb 20 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

626107

Registered No.

JO #91966

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days

(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County.....

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 525 N. Gilmore St.

(If rural give location)

(e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

3 (a) FULL NAME Mary E. Hanson Henson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1867

8. AGE: Years	Months	Days	If less than one day
77	-4-	-5-	..... hr. ..... min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER

12. Name James Hanson

13. Birthplace Maryland

MOTHER

14. Maiden Name Clara Dobson

15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 2-22-45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Baltimore

18 (a) Funeral director Sam'l H. Chase Sons

(b) Address 638 N. Gilmor St

19 (a) 2-1 1945 (b) Huntington Williams, M.D.

(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17, 19 45 at 2:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5, 19 45 to Feb. 17, 19 45, and that I last saw h er alive on Feb. 17, 19 45.

Immediate cause of death	Duration
Cardiac failure	?
Due to Arteriosclerotic heart disease & renal trouble	
Due to.....	
Other Conditions Lobar pneumonia Pulmonary congestion	3 days?

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at..... M

(c) Where did injury occur?.....

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....

(Specify type of place)

(e) Means of injury.....

23. Signature E Woodward M. D.

Address Baltimore City Hospitals Date signed 10-18-45

VS 150

93D

626103

BALTIMORE CITY HEALTH DEPARTMENT 626108
CERTIFICATE OF DEATH 83a Registered No.

626103

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2914 Belmont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 Belmont Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Williams

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-6089

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Mary Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1858

8. AGE: Years 87 | Months 1 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired Supt. Waverly Press

11. Industry or business

FATHER
12. Name Thomas C. Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Louisa Williamson
15. Birthplace Md.

16 (a) Informant Mrs. Edith W. Bower
(b) Address 2914 Belmont Ave.,

17 (a) Burial (b) Date thereof Feb 22, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) (b)
(Date received by Registrar) Registrar

FEB 21 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19, 1945, at 2.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1945 to Feb 19 1945 and that I last saw him alive on Feb. 19. 1945.

Immediate cause of death	Duration
Due to cerebral hemorrhage & paralysis	12 days
Due to	
Other Conditions advanced arteriosclerosis (Include pregnancy within 3 months of death)	7

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter E. Wright M. D.
Address 2220 Garrison Blvd Date signed

X

Feb 20/45

626103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

626103 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1452 Montpelier St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1452 Montpelier St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine M. De Baufre

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Benjamin De Baufre
6 (c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) May 28, 1896
8. AGE: Years 48 | Months 8 | Days 21 | If less than one day ... hr. ... min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph W. Lynch, Sr.
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary C. Gillen
15. Birthplace Washington, D.C.

16 (a) Informant Benjamin De Baufre
(b) Address 1452 Montpelier St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/45 (month) (day) (year)
(c) Cemetery or crematory Woodland & Parks
Location Taylor Ave, Balto Co.

18 (a) Funeral director George J. Ruth's Sons
(b) Address 1735 Hartford Ave.

19 (a) ... (Date rec'd by registrar) (b) ... (Registrar)

FEB 21 1945 Huntington
VS 45

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21, 1945, at 8 A. M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Le Gru Graham M.D.
Medical Examiner.
Date signed Feb 21 1945

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G2611.0 — BALTIMORE CITY HEALTH DEPARTMENT — G2611.0

CERTIFICATE OF DEATH 942

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 years 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs. 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Chevy Chase
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 West Leland St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Lily F. Darcy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1885

8. AGE: Years	Months	Days	If less than one day
59	4	21	9 hr. 9 min.

9. Birthplace Royton, England (Town, county, and state)
10. Usual Occupation Secretary
11. Industry or business

FATHER
12. Name Thomas F. Darcy
13. Birthplace England

MOTHER
14. Maiden Name Margaret Hannigan
15. Birthplace England

16 (a) Informant Mount Hope Retreat
(b) Address 6 & 20 Reisterstown Road, Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-45 (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director James T. Ryan Co
(b) Address Washington, D.C.

19 (a) (Delivered by) (b) Huntington, West Virginia

FEB 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 1945, at 9:09 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1942 to Feb. 21 1945, and that I last saw her alive on Feb. 21 1945.

	Duration
Immediate cause of death Coronary Thrombosis	1 day
Due to General Arteriosclerosis	?
Due to	
Other Conditions Cerebrovascular with arterial Hypertension (Include pregnancy within 3 months of death)	3 years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Alaggia M. D.
Address 336 Frederick Ave. Date signed

626111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

✓ 626111 Registered No.

Print the causes of death clearly and legibly. Physicians: please write the cause or especially important. Physicians: please write the cause or especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 E. Fort ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert J. Moeller

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21. 1914

8. AGE: Years: 31 | Months: 11 | Days: 28 | If less than one day: hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Read Drug Co.

FATHER 12. Name John Moellar

13. Birthplace Balto, Md.

MOTHER 14. Maiden Name Margaret E. O'Boyle

15. Birthplace Balto, Md.

16 (a) Informant Leo Moeller

(b) Address 1330 E. Fort ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Balto. Md.

18 (a) Funeral director Flynn & Fleming

(b) Address 1400 Light St.

19 (a) FEB 21 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18-, 1945 at 12 45 P.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions Fracture-dislocation 1st Cervical vertebra
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-7-45 at 12 24/1 M.
(b) Where did injury occur? 1200 block E. Fort ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Pedestrian, struck by automobile

23. Signature Howard J. Moeller M.D.
Medical Examiner.
Date signed 2-19-45

VS 151

G26112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G26112

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 Light St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Kramer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lula

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-2-90

8. AGE: Years	Months	Days	If less than one day
? 54	3	16	hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Henry Kramer
13. Birthplace Ohio

MOTHER
14. Maiden Name Edith Chapman
15. Birthplace Ohio

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-45 (month) (day) (year)

(c) Cemetery or crematory Balto. National
Location Balto. Co., Md.

18 (a) Funeral director Fleming & Flynn
(b) Address 1426 Light St.

19 (a) 1945 (Date received by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1945 at 6 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1945 to Feb 18 1945 and that I last saw h[illegible] alive on Feb 18 1945

Immediate cause of death: Respiratory failure — Duration 4 da.
Due to: Lobar pneumonia
Due to:
Other Conditions: Pulmonary tuberculosis inactive
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

William J. Dixon
Johns Hopkins Hospital 2/19/45

VS 150

626113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 626113

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 S. Ann Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 S. Ann Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Kuc

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Anna Kuc

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Mrs. Mazan

(b) Address 106 S. Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 22 1945 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem

Location Baltimore County

18 (a) Funeral director John M. Weber

(b) Address 401 S. Chester Street

19 (a) FEB 21 1945 (b) Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1945, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1941, to Feb 18 1945, and that I last saw him alive on Feb 18 1945.

	Duration
Immediate cause of death Cerebral Hemorrhage	Feb 1945
Due to Arterio Sclerosis	1935
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Williams, Rhoads M. D.

Address 801 Kenwood Ave Date signed Feb 21 1945

Huntington Williams, M.D.

FURNISH WHAT IS ASKED, WITH ONE READING ONLY. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G26114
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 E. 33rd St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 E. 33rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE A. CRESAP

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William Lymm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1876

8. AGE: Years	Months	Days	If less than one day
69	0	0	hr. min.

9. Birthplace Alaska, W. Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name -- Neff
13. Birthplace W. Va.

MOTHER
14. Maiden Name Margaret Ramey
15. Birthplace White Post, Va.

16 (a) Informant Mr. William L. Cresap
(b) Address 621 E. 33rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

FEB 21 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20, 1945, at 4:05P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6/45 19 , to 2/20/45 , and that I last saw h alive on 2/20/45 .

Immediate cause of death Coronary Thrombosis — Duration Few hr.

Due to

Due to

Other Conditions Arterio-sclerotic Heart Failure
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Zach. A. Morgan M. D.
Address 6 E. Read St. Date signed 2/21/45

VS 150

5115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V G26115

51B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4409 Williams Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mr. Jolan Halas

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Ida G. Halas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/25/79

8. AGE: Years 65 | Months 10 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation Black Smith & Welding

11. Industry or business Self

FATHER
12. Name --
13. Birthplace --

MOTHER
14. Maiden Name --
15. Birthplace --

16 (a) Informant Mr. Alexander C. Halas
(b) Address 134 Palormo Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 21 1945 (Date rec'd by registrar) Huntington Williams M.F. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21/45 19..., at 7:15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/19 1945, to 2/21 1945, and that I last saw him alive on 2/20 1945

Immediate cause of death Bronchopneumonia — Duration 7 days

Due to

Due to — over

Other Conditions Metastatic Carcinoma of Lungs — 5
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard C. Hayden M. D.
Address Bon Secours Hosp Date signed 2/26/45

VS 150

107

626116 ✓ 626116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1578

626116 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1629 Ensor St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Ensor St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kathleen McKinney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed,~~ or ~~divorced~~.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20th 1945

8. AGE: Years	Months	Days	If less than one day
	1	-	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business child

FATHER 12. Name Robert L McKinney

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Evelyn Bond

15. Birthplace Baltimore Md

16 (a) Informant Evelyn McKinney

(b) Address 1629 Ensor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 22/45 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Fredrick Road

18 (a) Funeral director John C Moran

(b) Address 3000 Baltimore St

19 (a) FEB 21 1945 (Date rec'd by local registr.) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3/45 19 to 2/21/45 19, and that I last saw h e alive on 2/20/45 19.

Immediate cause of death	Duration
Mal formed Child	
Due to Spina Bifida	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter C Bacon M. D.

Address 1002 Eutaw St Date signed 2/22/45

X

G26117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

99

Registered No. G26117

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 17 ds
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 526 N. POTOMAC ST. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MR. JOHN HUDAK (HUDACK)

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 213-10-1397

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife (nee Ceska) BEATRICE M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/14/93

8. AGE: Years	Months	Days	If less than one day
51	10	7	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation CONDUCTOR -- B.T. WELF
11. Industry or business

FATHER
12. Name Stephen Hudak
13. Birthplace Austria

MOTHER
14. Maiden Name Leskovyanski
15. Birthplace Austria

16 (a) Informant Mrs. Beatrice Hudak
(b) Address 526 N. Potomac Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) FEB 21 1945 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21/45 19-, at 8:26 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/3/ 1945, to 2/21 1945, and that I last saw h/M alive on 2/21 1945.

Immediate cause of death: THROMBOSIS OF FEMORAL ARTERIES — Duration
Due to: ARTERIOSCLEROSIS
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 1/13/45
Major findings of operation: THROMBOSIS of R. femoral
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harvey E. Wallace M. D.
Address 1400 N. Caroline St. Date signed 2/24/45

VS 150

X

626118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 626118

Every item of information should be carefully supplied. Write plainly, with unfading ink. Especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2129 Jefferson Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2129 Jefferson Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Annette Mary Novak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife James Frank Novak
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1873

8. AGE: Years	Months	Days	If less than one day
71 yrs.	9	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Rokosky
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name unknown
15. Birthplace Czechoslovakia

16 (a) Informant husband
(b) Address 2129 Jefferson Street

17 (a) Burial (b) Date thereof 2/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) Filed 2-21-1945 Huntington Williams, M.D.
(Date filed) (By Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19-1945, at 4 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8-1944, to 2-19-1945, and that I last saw her alive on 2-17-1945.

Immediate cause of death	Duration
Chr. cardio-vascular-renal disease	Fourteen years
Due to Arteriosclerosis	Fourteen years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. B. Sylvester M. D.
Address 1802 Harford Rd. Date signed 2-20-45

VS 150

626119

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 (62612) Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Shook

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Real Estate Agent
11. Industry or business

FATHER
12. Name Albert Shook
13. Birthplace Baltimore

MOTHER
14. Maiden Name Suzanne Laborne
15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 22, 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Cummonwealth Ave

19 (c) 2-21-1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1945, at 8:34 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Feb 21 1945, and that I last saw him alive on Feb 20 1945

Immediate cause of death	Duration
Edema of Lungs	1 day
Due to Chronic myocarditis	5 yrs
Due to	
Other Conditions Arterio Sclerosis	10 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bill Hall M. D.
Address 1631 E North Ave Date signed Feb 21-45

X

626120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

626120

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
Adm. 1/4/45 - 6:00 P.M.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 Orchard Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BEN JENKINS

3 (b) If veteran, name war	3 (c) Social Security Account No. 220-07-4340

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/27/1888

8. AGE: Years	Months	Days	If less than one day
56	9	20	hr. min.

9. Birthplace ? Ala
(Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business Merchant Marine

FATHER
12. Name Taylor Jenkins
13. Birthplace ? Ala

MOTHER
14. Maiden Name ? Bell
15. Birthplace ?

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Annapolis Rd.

18 (a) Funeral director L. Lee Ader
(b) Address 4644 York Rd.

19 (a) (Date received by registrar) FEB 21 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Feb. 16, 1945, at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 4, 1945 to Feb. 16, 1945, and that I last saw h im alive on Feb. 16, 1945.

Immediate cause of death Lymphosarcoma — Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1/5/45-Ingision & Drainage of abscess of scrotum; 1/23/45-Thoracentesis.

Findings of autopsy: Abscess of scrotum

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin F. Jones M.D.
Address Baltimore, Md. Date signed 2/16/45

MS-58029

26121

BALTIMORE CITY HEALTH DEPARTMENT ✓ G26121

CERTIFICATE OF DEATH 469

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1635 E. 32nd St.
(c) Hospital or institution: ——
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1635 E. 32nd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Louisa M. Heemann

3 (b) If veteran, name war —— | 3 (c) Social Security Account No. ——

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Louis

6 (c) If alive give age —— years

7. Birth date of deceased (mo., day, yr.) Dec 26 1865

8. AGE: Years 79 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Frederick Kalthof
13. Birthplace Germany

MOTHER
14. Maiden Name Venzella Bohn
15. Birthplace Germany

16 (a) Informant Mr. Frederick Heemann
(b) Address Mossway. Ft. 22 45

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 22 45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Linden Lane

18 (a) Funeral director L. Hecmann & Son
(b) Address 32 S. Broadway.

19 (a) Date received by local registrar FEB 21 1945 (b) Registrar Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1945 at 3:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18, 1945 to Feb 19, 1945 and that I last saw her alive on Feb 18, 1945.

Immediate cause of death	Duration
Coronary thrombosis	5 days
Due to Arteriosclerosis	?
Due to	
Other Conditions Carcinoma of pancreas with extension to stomach (Include pregnancy within 3 months of death)	?

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice E. Shaman M. D.
Address 3300 N. Howard Date signed 2/24/45

94a

26122 BALTIMORE CITY HEALTH DEPARTMENT G26122

CERTIFICATE OF DEATH

95B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23 Rd 4 + St Paul.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middleriver (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Elm Davis (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Genevieve La France

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jeremie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 2, 1919

8. AGE: Years 25 | Months 9/10 | Days 19 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Anthony Gajewski

13. Birthplace Poland

MOTHER 14. Maiden Name Aurelie Pomerayne

15. Birthplace Poland

16 (a) Informant Jeremie La France

(b) Address Elm Davis Middle River

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 21, 1945 (month) (day) (year)

(c) Cemetery or crematory New Bristol

Location Mass.

18 (a) Funeral director Wm Cook Inc

(b) Address St Paul & Preston St.

19 (a) FEB 21 1945 (Date rec'd by registrar) (b) Huntington Williamsport Pa

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1945 at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sep 22 1944 to Feb 21 1945, and that I last saw him alive on Feb 21 1945.

Immediate cause of death	Duration
Acute Cardiac dilatation	3 days
Due to Rheumatic heart disease	6 mos.
Due to Subacute Bacterial endocarditis.	3 mos.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harvey J. Beck M. D.

Address Date signed 2-21 /45

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26123 ✓ G26123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13W

Registered No.

Duplicate of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 710 ST PAUL STREET
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 St Paul St
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT MEEHAN

3 (b) If veteran, name war

3 (c) Social Security Account No. NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED ~~WIDOWER~~

6 (b) Name of husband or wife LOUISA TAYLOR

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) MAR. ? 1880

8. AGE: Years	Months	Days	If less than one day
64	MARCH		hr. min.

9. Birthplace LINDSAY ONT. CANADA
(Town, county, and state)

10. Usual Occupation MUSICIAN

11. Industry or business

FATHER
12. Name PATRICK MEEHAN
13. Birthplace IRELAND

MOTHER
14. Maiden Name ~~MARGARET~~ ELLEN LUCAS
15. Birthplace IRELAND

16 (a) Informant LOUISA TAYLOR MEEHAN
(b) Address 710 ST PAUL ST

17 (a) Burial (b) Date thereof Feb 22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Green Mount
Location Balto Md

18 (a) Funeral director Henry McJenkins Sons
(b) Address Mc Cullh & Orchard Sts

19 (a) (b) Huntington Williams
(Date received by Registrar)

FEB 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/20 1945 at 3.08 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/18 1945 to 2/20 1945; and that I last saw him alive on 2/20 1945.

Immediate cause of death	Duration
Arteriosclerosis	
Uremic Poisoning	1 wk.
Due to Chr. Nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S H Bannerman M. D.

Address 436 E Fort Ave Date signed 2/21/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26124 — BALTIMORE CITY HEALTH DEPARTMENT — G26124 Registered No.

CERTIFICATE OF DEATH 940

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2515 Pickwick Rd
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 8
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2515 Pickwick Rd.
(If rural give location)
(e) Citizen of foreign country? —(Yes or No)
If yes, name country

3 (a) FULL NAME Howard Elmer Ashbury

3 (b) If veteran, name war: 1st & 2nd World
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Ellen Hicks Ashbury
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) 4/26/1880

8. AGE: Years	Months	Days	If less than one day
64	9	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Joseph Martin Ashbury
13. Birthplace Mathews, Va.

MOTHER
14. Maiden Name Emma Bartlett
15. Birthplace Mathews, Va.

16 (a) Informant H. H. Ashbury
(b) Address 6 Hillside Rd.

17 (a) Removal (b) Date thereof Feb 22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Arlington National
Location Arlington Va.

18 (a) Funeral director Kirby Hopkins & Sons
(b) Address 24 E. Eager St.

19 (a) FEB 21 1945 (b) Huntington Williams MD
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1945, at 10:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/19 1945, to 2/20 1945, and that I last saw him alive on 2/20 1945

Immediate cause of death	Duration
Coronary Thrombosis	2 days,
Due to Arteriosclerosis	2 years.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard H. Ashbury
Address 6 E. Eager St. Date signed 2/4/45

X

G26125 — BALTIMORE CITY HEALTH DEPARTMENT — G26125 Registered No.

CERTIFICATE OF DEATH 46 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1435 Cherry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1435 Cherry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Stammer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Gottlieb Stammer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 2, 1893

8. AGE: Years 51 | Months 2 | Days 17 | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER 12. Name John Halewoda
13. Birthplace Austria

MOTHER 14. Maiden Name Not known
15. Birthplace Austria

16 (a) Informant Frank Schultz
(b) Address 1434 Cherry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-45 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Hechinger Drive Md

18 (a) Funeral director Frank Robertson
(b) Address 900 N Chester St

19 (a) FEB 21 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to Feb 19 1945, and that I last saw her alive on Feb. 19 1945.

Immediate cause of death Hemathemesis — Duration

Due to cancer of the stomach

Due to

Other Conditions generalized carcinoma

(Include pregnancy within 3 months of death)

Date of operation December 1944

Major findings of operation: inoperable Carcinomatosis ventriculi

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank Neuhauser M. D.
Address 914 Patapsco Ave. Date signed Feb 20 1945

X

G26126 MORRIS Eisenberg G26126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Maryland General Hospital 15/12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 41

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (if outside city or town limits, write RURAL and give town)
(d) Street No. 2907 Springhill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Morris Eisenberg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Belle
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) January 20, 1872

8. AGE: Years	Months	Days	If less than one day
73	1	—	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Merchant

FATHER
12. Name Abraham Eisenberg
13. Birthplace Russia

MOTHER
14. Maiden Name Gertrude ?
15. Birthplace Russia

16 (a) Informant Aaron Eisenberg
(b) Address 2907 Springhill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 22, 1945 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 FEB 22 1945 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1945, at 6 P, M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-19 1945, to 2-20 1945, and that I last saw him alive on 2-20 1945.

Immediate cause of death Coronary Thrombosis — Duration

Due to ACVD & failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Wagner
Address Md. Gen'l Hosp. Date signed 2/20/45 M. D.

X

G26127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. G26127

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 S. Hanover St.
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Paul A. Jones

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age — years

7. Birth date of deceased (month, day, year) Sept 4th 1899

8. AGE: Years	Months	Days	If less than one day
about 44	5	16	..... hr. ..... min.

9. Birthplace Kensville Pa
(Town, county, and state)
10. Usual Occupation Battery Man
11. Industry or business Bowers & Taylor

FATHER
12. Name (Unknown) Jones
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant George A. Hobler
(b) Address Hoyt & Mt Royal Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/45 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie Md
18 (a) Funeral director Millhorn & Doe
(b) Address 1219 E Lond St
19 (a) Date received by local registrar FEB 22 1945 Hunting for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20, 1945, at 3 40 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Primary Squamous Carcinoma
of Lung.
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury.....

23. Signature Howard J. Mudd M.D.
Medical Examiner.
Date signed 2-21-45

VS 151

626128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 626128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5204 Alhambra Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sydney R. Whiteway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband of~~ wife Bertha Whiteway

6 (c) If alive, give age 1893 years

7. Birth date of deceased (mo., day, yr.) Oct 6th 1884

8. AGE: Years 61 | Months 4 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Sydney Australia
(Town, county, and state)

10. Usual Occupation Maintenance Man

11. Industry or business General Elevator Co.

FATHER
12. Name (Unknown) Whiteway
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Alan R. Wilson
(b) Address 5204 Alhambra Ave

17 (a) Burial (b) Date thereof 2/24/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) FEB 22 1945 Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23 1945, at 9:00 P M

21. I certify that I took charge of the remains described above, held an Inquest-Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Clayton Tolmie M.D.
Medical Examiner.
Date signed 2/25/45

(Over)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

6126129 ✓ BALTIMORE CITY HEALTH DEPARTMENT 94a Registered No. 6126129

CERTIFICATE OF DEATH

Every item of information should be carefully reported. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINCIPAL PARTS PLEASE, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution: Inst Jewish Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2240 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LEAH GRANOFF ARONCHIK

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Not Known

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1862

8. AGE: Years: 83 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation:

11. Industry or business

FATHER
12. Name: Not Known
13. Birthplace: Russia

MOTHER
14. Maiden Name: Not Known
15. Birthplace: Russia

16 (a) Informant: Louis Granoff
(b) Address: 2240 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-45 (month) (day) (year)
(c) Cemetery or crematory: Bnai Israel
Location: Southern Ave

18 (a) Funeral director: Jack Levin Inc
(b) Address: 1439 E. Baltimore St

19 (a) FEB 22 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21-1945, at 2 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1933 19 , to 2-21 1945, and that I last saw he alive on 2-21-45 19 .

Immediate cause of death: coronary sclerosis — Duration: ?

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Theodore Kurland M.D.

Address: 2904 Reed Rd Date signed: 2-22-45

VS 150

626130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

626130 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item o. information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3407 TANNEY ROAD
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-20
(e) Length of stay in Baltimore (yrs., mos., or days) 60 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3407 TANNEY RD (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MORRIS D. ROBINSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife JENNIE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation ATTORNEY
11. Industry or business

FATHER
12. Name ABRAHAM ROBINSON
13. Birthplace RUSSIA

MOTHER
14. Maiden Name LEAH
15. Birthplace RUSSIA

16 (a) Informant JENNIE ROBINSON
(b) Address 3407 TANNEY RD.

17 (a) (Burial, cremation, or removal) (b) Date thereof 2-23-45 (month) (day) (year)
(c) Cemetery or crematory BALTO. HEBREW
Location BELAIR ROAD.

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST

19 (a) FEB 22 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 21 1945, at 5:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 1945, to Feb 21 1945, and that I last saw him alive on Feb 20, 1945.

Immediate cause of death Thrombosis of left middle cerebral Artery — Duration 21 days
Due to Arterio-Sclerosis (cerebral)
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Pushkin M. D.
Address 2338 Eutaw pl. Date signed 2-21-45

G26131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G26131

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1636 E. 32nd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1636 E. 32nd St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah D. Hodland.

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Roland G. Hodland

6 (c) If alive, give age 87 years

7. Birth date of deceased (mo., day, yr.) April 11, 1863

8. AGE: Years 81 | Months 10 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William
13. Birthplace Baltimore

MOTHER
14. Maiden Name Hannah Dorsey
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Joseph C. Smith
(b) Address 1636 E. 32nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Greenmount & Alva Ave.

18 (a) Funeral director Howard H. Blight Jr.
(b) Address 4914 Belair Road.

19 (a) FEB 23 1945 (Date received by Local Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1945, at 3.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1945, to Feb 21 1945, and that I last saw h.w. alive on Feb 21 1945.

Immediate cause of death	Duration
Coronary occlusion	
Due to	
Due to	
Other Conditions Hypertension	2 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jacob Frisch M. D.
Address 1800 N. Mad. St. Date signed 2/24/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26132 G26132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 | a Registered No. V

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 734 S. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Willard Fox

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name Harvey J. Fox
13. Birthplace North Carolina

MOTHER
14. Maiden Name Edge
15. Birthplace North Carolina

16 (a) Informant Robert Orr
(b) Address 116 Jackson Square

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 22 1945 (month) (day) (year)
(c) Cemetery or crematory Burnville
Location North Carolina

18 (a) Funeral director Wm Cox
(b) Address Balto Md

FEB 22 1945 (Date rec'd by registrar) (b) Hunting for Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1945, at 8:35 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio vascular-renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Feb. 21 1945

X

G26133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G26133 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 E. Center Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie A. Drew

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26th 1864

8. AGE: Years 80 81 | Months 6 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Wisconsin
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Michael Kluge
13. Birthplace Wisconsin

MOTHER
14. Maiden Name Sophia Keeler
15. Birthplace Wisconsin

16 (a) Informant Mrs. Anna A Kluge
(b) Address 1323 Clifton St. N.W. Washington D.C.

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof Feb 23rd (Month) (Day) (Year)
(c) Cemetery or crematory Loudon Park Cem
Location Balto Md.

18 (a) Funeral director Leo D. Cook
(b) Address 1701/03 N. Patt Pk. Ave

FEB 22 1945 (Date rec'd by local registrar) (b) Huntington Williams (Signature)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21- 1945, at 8 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 2-21-45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-6134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G-6134

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 916 E. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ellie Johnson
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) April 3 1872

8. AGE: Years	Months	Days	If less than one day
73,	10	15	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Richmond
15. Birthplace Johns Hopkins Hospital

16 (a) Informant Johns Hopkins Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 23 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore County
Location York Rd. & Ridgely Rd.

18 (a) Funeral director Wendell P. Bissel
(b) Address 312-8 Highland Ave.

19 FEB 22 1945 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1945 at 11.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18 1945 to Feb. 18 1945 and that I last saw him alive on Feb. 18 1945

Immediate cause of death	Duration
Lobar pneumonia	
Due to Pneumococcus	
Due to	
Other Conditions Arteriosclerotic heart disease Cardiac failure. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Katten
Address Johns Hopkins Hosp. Date signed 2/19/45

VS 150

X

M. D. B. 13000

G26135 ✓ G26135

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 108

1. PLACE OF DEATH

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 7 N. Amity St., Ward)

Length of residence in city or town where death occurred ...yrs. ...mos. ...ds. How long in U. S. If of foreign birth? ...yrs. ...mos. ...ds.

2. FULL NAME Nellie Adger

(a) Residence: No. 7 N. Amity St., 18-1 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Married

5a. If married, widowed, or divorced (or) WIFE of President Adger

6. DATE OF BIRTH (month, day, year) Oct. 27, 1918

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	26	3	21	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Waynesboro D. C.

FATHER

13. NAME Eddie Tyles

14. BIRTHPLACE (city or town) (State or country) Waynesboro D. C.

MOTHER

15. MAIDEN NAME Maria Pinkney

16. BIRTHPLACE (city or town) (State or country) Waynesboro D. C.

17. INFORMANT Lzetta Davis
(Address) 7 N. Amity St.

18. BURIAL, CREMATION, OR REMOVAL
Place Mt. Auburn Date Feb 22, 1945

19. UNDERTAKER Mrs. Katie R. Williams
(Address) 523 N. Schroeder St.

20. FILED FEB 22 1945 Hattie Lee Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb. 18, 1945

22. I HEREBY CERTIFY, That I attended deceased from Feb 16, 1945 to Feb 18, 1945

I last saw her alive on Feb 18, 1945. Death is said to have occurred on the date stated above, at 5 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	3 days

Other contributory causes of importance:

Bronchitis,	1 wk

Name of operation ..... Date of .....

What test confirmed diagnosis? Clinical. Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) McDonald Bando M. D.

(Address) 2445 Druid Hill Ave.

OCCUPATION is very important. See instructions on back of certificate.

V. S. 3

G26135

JO #87925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

307

G26135

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos. 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1205 Chatham St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Porter Powell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6. (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1870

8. AGE: Years	Months	Days	If less than one day
74	11	-8-	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Fanny Powell (d)

13. Birthplace North Carolina

MOTHER

14. Maiden Name Nellie Smith (d)

15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location a. a. Co Md

18 (a) Funeral director Isaiah L. Dorsey & Son

(b) Address 1960 W Montgomery St

19 FEB 23 1945 (Date rec'd by registrar) Huntingtor Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15, 1945 at 3:20PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 22, 1944 to Feb. 15, 1945, and that I last saw him alive on Feb. 15, 1945.

Immediate cause of death	Duration
Bronchopneumonia	3 days?
Due to	
Due to	
Other Conditions Arteriosclerotic heart disease Syphilitic aortitis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E Woodward M. D.

Address Baltimore City Hospitals Date signed 2-18-45

PRESS WHITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

107

G26137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

Registered No. G26137

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Carrollton Ave.

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da

(e) Length of stay in Baltimore (yrs., mos., or days) 11 da

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore 19

(If outside city or town limits, write RURAL and give township)

(d) Street No. 3014 Harford Ave. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Linda Phillips

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8 - 1945

8. AGE: Years | Months | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Raymond D. Phillips

13. Birthplace West Virginia

MOTHER

14. Maiden Name Varamae Dunnenberry

15. Birthplace West Virginia

16 (a) Informant Frances E. Burton

(b) Address 5 Northship Rd. Dundalk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 / 22 / 45 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cemetery

Location Baltimore, Md.

18 (a) Funeral director H. W. Meyerson

(b) Address 605 N. Calvert St.

19 (a) FEB 22 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21 1945, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/19 1945, to 2/21/1945, and that I last saw h[illegible] alive on 2/2/1945

Immediate cause of death	Duration
Edema of larynx	
Due to atelectasis	
Due to Cardiac failure	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Louis J. Ball Jr. M.D.

Address St. Joseph's Hosp. Date signed 2/21/45

VS 150

626138 ✓ 626138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2146 Vine St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2146 Vine St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Edward M. Kelly

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Sophia M. Kelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15th 1865

8. AGE: Years	Months	Days	If less than one day
79	5	6.	hr. min.

9. Birthplace Canada (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Kelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Jean McCelvie
15. Birthplace Scotland

16 (a) Informant Mrs Lefroy Pfeifer
(b) Address 2146 Vine St —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director John J Cowan & Son
(b) Address 901-03 Wilkens Ave

19 (a) [illegible] Huntington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Febry 21st 1945, at 2.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1st 1942 to Feb 21st 1945, and that I last saw h[illegible] alive on Feb 20th 1945.

Immediate cause of death	Duration
uraemia URAEMIA	48 hrs
Due to Arteriosclerosis	
Due to Chronic nephritis	4 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. J. McGowan M.D.
Address 1136 Poplar Grove St Date signed 2/21/45

X

G26139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G26139

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4025 Park Heights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-12
(e) Length of stay in Baltimore (yrs., mos., or days) 44 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4025 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emilia Cicchetti

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~XXXXX~~ Vito Cicchetti
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27 1880

8. AGE: Years 65 | Months | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Castelbaronia-Avellino Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business home

FATHER
12. Name Generoso - Lombardi
13. Birthplace Italy

MOTHER
14. Maiden Name Vita Maria Novia
15. Birthplace Italy

16 (a) Informant Vito Cicchetti (Husband)
(b) Address 4025 Park Heights

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 23 1945 (month) (day) (year)
(c) Cemetery ~~XXXXXXXX~~ Holy Redeemer Cem.
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Noce
(b) Address 52 N. Morley St.

19 (a) FEB 23 1945 (b) Huntington Wilson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19-1945, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-11-1945 to 2-19-1945, and that I last saw h~~er~~ alive on 2-17-1945

	Duration
Immediate cause of death Diabetes	44 Yrs
Coma —	yrs
Due to Diabetes —	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. J. Emanuel M. D.
Address Medical Arts Bldg. Date signed

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

66140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. 66140

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3000 Pellona Avenue
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 Lamont Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA MAE BARRETT

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-24-8470

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Frederick Wm Barrett
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 8, 1881

8. AGE: Years	Months	Days	If less than one day
63	7	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Hollenshade
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Alberta Hunt
15. Birthplace Baltimore, Md.

16 (a) Informant Harry A. Barrett (son)
(b) Address 1 E. Preston Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Md

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) FEB 23 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20, 1945 at 11.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 13 1944, to 2/18 1945 and that I last saw h[er] alive on 2/18 1945.

Immediate cause of death: Acute cardiac failure — Duration

Due to: Ch. General Arterio Sclerosis

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Aisquith St Date signed 2/21/45

G66141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G66141

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5310 CHANDLER. AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE 1
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5310 CHANDLER AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY DEICHMILLER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEM. | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife. JOHN DEICHMILLER

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) NOV 6 186[illegible]

8. AGE: Years 83 | Months 3 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation HOUSE WORK

11. Industry or business AT HOME

FATHER
12. Name WILLIAM ENGELHAUPT.
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARY SCHREINER.
15. Birthplace GERMANY.

16 (a) Informant EMMA HORLEBEIN
(b) Address 5310 CHANDLER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-23-45 (month) (day) (year)

(c) Cemetery or crematory ST PAULS CEM
Location VIOLETSVILLE MD

18 (a) Funeral director Mrs Chas A. J Rohde
(b) Address 2327 EDMONDSON AVE

FEB 23 1945 (b) Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 21 1945, at 5:41 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1943 to Feb 21 1945, and that I last saw h[illegible] alive on Feb 20 1945.

	Duration
Immediate cause of death Hypostatic Pneumonia	6 day
Due to Myocarditis	10 days
Due to Rt Hemiplegia	3 Mos
Other Conditions Senility, Erosive Sclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: ✓

✓

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature. Howard Kalm M.D.

Address 2027 McCulloh St Date signed 2/24/45

VS 150

X

G26142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G26142

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 651 W. Conway St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John Samaras

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	M

6 (b) Name of husband or wife Fanny Samaras

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Baker

11. Industry or business

FATHER
12. Name Theodore Samaras
13. Birthplace Greece

MOTHER
14. Maiden Name Ekaterini Scrimis
15. Birthplace Greece

16 (a) Informant Gus Meligotis
(b) Address 3 Pt. Point

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 23, 1945 (month) (day) (year)
(c) Cemetery or crematory Cemetary Greek Woodlawn
Location Baltimore Md

18 (a) Funeral director J. Francis Reese
(b) Address Westminster

19 FEB 23 1945 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/20/ 1945, at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/18 1945 to 2/20 1945, and that I last saw him alive on 2/20 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral Hemorrhage	
Due to Cardio-Renal Disease + Diabetes Mellitus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bryan M. D.
Address St. Agnes Hosp Date signed 2/20/45

836

626143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 626143

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 S. Payson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 S. Payson Street (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Carolina Elizabeth Marley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William E. Marley
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) March 16, 1863

8. AGE: Years	Months	Days	If less than one day
82	11	5	hr. ____ min.

9. Birthplace Frederick County Md.
(Town, county, and State)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name David Leather
13. Birthplace Maryland

MOTHER
14. Maiden Name Susan Jane ?
15. Birthplace Maryland

16 (a) Informant George Marley
(b) Address 318 S Payon Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Maryland.

18 (a) Funeral director George H. Schwab
(b) Address 2101 Frederick Avenue

FEB 23 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 1945, at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1945 to February 21 1945, and that I last saw he alive on Feb 20 1945.

Immediate cause of death Hypostatic Congestion
Cardio vascular Renal
Hemiplegia - Arteriosclerosis

Due to	Duration
Due to	
Other Conditions Pulmonary Edema	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mabel C. Nitsch M. D.
Address 2151 Walbrook Ave Date signed 2/24/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G26144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G26144

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3734 Chestnut ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie J. Kirby

3 (b) If veteran, name war –

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21 1880

8. AGE: Years 64 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name John Kirby
13. Birthplace Md.

MOTHER
14. Maiden Name Agnes Blades
15. Birthplace Md

16 (a) Informant Eliz. Pratt
(b) Address 3734 Chestnut ave

17 (a) Baltimore (Burial, cremation, or removal) (b) Date thereof Feby. 24 45 (month) (day) (year)
(c) Cemetery or crematory Loyola Cemetery
Location St. Michaels Md

18 (a) Funeral director John O. Mitchell
(b) Address 950 Eutaw Place

19 (a) FEB 23 1945 (b)
(Date rec'd by registrar) Registrar

Huntingtown, Williams, Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21- 1945, at 11 35 P.M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage
Apoplexy

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mulder M.D.
Medical Examiner.
Date signed 2-22-45

626145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 626145

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 BEAUMONT AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-10
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 533 BEAUMONT AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: BLANCHE S. ANDERSON

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Wm. C. ANDERSON

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 9. 1858

8. AGE: Years 86 | Months 4 | Days 11 | If less than one day hr. min.

9. Birthplace DORCHESTER CO. MD. (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name LEVIN H. STEWART
13. Birthplace MD.

MOTHER
14. Maiden Name ELIZABETH PATTISON
15. Birthplace MD.

16 (a) Informant ELIZABETH A. BAYNARD
(b) Address 533 BEAUMONT AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 23.45 (month) (day) (year)
(c) Cemetery or crematory CAMBRIDGE CEMETERY
Location CAMBRIDGE MD.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 EUTAW PLACE

19 (a) (Date rec'd by registrar) Huntington for Williams

FEB 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 20.1945 19 , at 9.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15/45 1945, to 2/20 1945.
and that I last saw her alive on 2/20 1945.

Immediate cause of death	Duration
Cerebral hemorrhage.	6 days.
Due to Cerebral arterio-sclerosis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Willis Grayton M. D.
Address 3963 GREENMOUNT AVE. Date signed

X

26146

BALTIMORE CITY HEALTH DEPARTMENT X 157E ✓ Registered No. 26146

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTIMORE
(c) City or town ESSEX 1621 Gail Rd
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 Gail Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Neat

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/17/45

8. AGE: Years	Months	Days	If less than one day
			2 hr. min.

9. Birthplace Doctors Hospital (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Neat
13. Birthplace Westminster Md

MOTHER
14. Maiden Name Mary Bachus
15. Birthplace Westminster Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 21 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 23 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-17 1945, at 10.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-17-1945, to 2-17-1945, and that I last saw h[illegible] alive on 2-17-1945.

Immediate cause of death Congenital Heart Disease
Due to Open Foramen Ovale
Due to Dextrocardia
Other Conditions Prematurity
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis J. Gluck M. D.
Address 720 Wolfe St Date signed

VS 150

2530 X 2/21/45

Correct name of deceased, with given name and middle name, should be entered. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626147

468133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

626147

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 N. Caste St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hamilton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Black	married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 11-13-03

8. AGE: Years	Months	Days	If less than one day
41	3	10	..... hr. ..... min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Willis Hamilton
13. Birthplace N. C.

MOTHER
14. Maiden Name Rachal ? ?
15. Birthplace N. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2 26 45
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem Cemetery
Location Arbutus Md

18 (a) Funeral director William J Jackson
(b) Address 916 Penna ave

19 (a) FEB 23 1945 (b) Hunter's for Williams MD
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1945, at 2.25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1945, to Feb 22 1945, and that I last saw him alive on Feb 22 1945.

Immediate cause of death	Duration
Disseminated Sclerosis	
Due to Arteriosclerotic cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J Dyer
Address Hopkins Hosp Date signed 2-23-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

626148 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5717 Rusk Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5717 Rusk
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Collins Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Henry Young

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 17 1856

8. AGE: Years 88 | Months 11 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name James H Collins
13. Birthplace ?

MOTHER
14. Maiden Name Hetty L Christopher
15. Birthplace

16 (a) Informant Chas F Snyder
(b) Address 5717 Rusk Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/25/45 (month) (day) (year)

(c) Cemetery or crematory Bethany Meth Cem
Location Pocomoke Md

18 (a) Funeral director Dennis & Watson
(b) Address Pocomoke Md

19 (a) [illegible] (b) Huntington Milli... M.D.

FEB 23 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1945, at 9 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1945, to Feb 22 1945, and that I last saw her alive on Feb 22 1945.

Immediate cause of death Terminal Bronchopneumonia — Duration 2 days

Due to Chronic Cardio-Vascular Renal disease — 20 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury

23. Signature Joseph L Zuerlein M. D.
Address 238 Main St Pocomoke Date signed 2/27/45

X

G26149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G26149

Please write plainly with pen, using unfading ink. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3525 Liberty Hgts. Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3525 Liberty Hgts. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA L. A. GOLDEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Widow

6 (b) Name of husband or wife George W. Golden, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1864

8. AGE: Years	Months	Days	If less than one day
80	3	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name H. L. Diering
13. Birthplace Germany

MOTHER
14. Maiden Name -- Rausch
15. Birthplace Germany

16 (a) Informant Mr. George W. Golden
(b) Address 3525 Liberty Hgts. Ave.

17 (a) Burial (b) Date thereof 2/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
Registrar

FEB 23 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20, 1945, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 16 1945, to Feb. 20 1945, and that I last saw her alive on Feb. 19 1945.

Immediate cause of death	Duration
Coronary thrombosis.	
Due to	
Due to	
Other Conditions Grippe	5 days.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm J Schmitt M. D.
Address 701 N. Kenwood Ave. Date signed 2/21/45

626150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

626150

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2634 McElderry St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2634 McElderry St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMELIA HELMER

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Julius C. Helmer

6 (c) If alive, give age : years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1864

8. AGE: Years 81 | Months 0 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name --
13. Birthplace

MOTHER
14. Maiden Name --
15. Birthplace

16 (a) Informant Mrs. Oscar Helmer

(b) Address 1820 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/45 (month) (day) (year)

(c) Cemetery or crematory Western Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Date received by registrar) FEB 23 1945 (b) Huntington, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21, 1945 at 8:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 1945 to 2/21 1945, and that I last saw h[illegible] alive on 2/20 1945.

Immediate cause of death	Duration
myocardial insufficiency	2 wks.
Asthenia	?
Due to carcinoma of stomach	2 Yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature L. C. Whitted

Address 4474 N. Kenwood Ave Date signed 2/23/45 M. D.

X

Fill in items with information as complete as possible. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G26151

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 Overdale Rd
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 28-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Overdale Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret L. Trott

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Frank B Trott.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day. yr.) Nov-17-1872

8. AGE: Years	Months	Days	If less than one day
72	3	2	hr. min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business —

MOTHER / FATHER
12. Name Daniel Tatum
13. Birthplace Md
14. Maiden Name Mary Spechtler
15. Birthplace Md

16 (a) Informant Mrs Stanley Trott
(b) Address 519 Overdale Rd.

17 (a) Burial (b) Date thereof 2-22-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Balto Md

18 (a) Funeral director Geo. L Beyer Jr
(b) Address 1512 Hollins St.

19 (a) FEB 22 1945 Huntington Williams, M.D. Baltimore, Md.
(Filed) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1945, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1945 to Feb 19 1945, and that I last saw h[er] alive on Feb 19 1945.

Immediate cause of death	Duration
Coronary Thrombosis	4 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. P. Von Schulz M.D.
Address 1818 Edmondson Ave Date signed 2/22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be made for each item of information. Where any item is unknown, supply the correct answer if possible. If there is no person in attendance at the death, or if the attendant is not certain as to the cause of death, the case must be referred to the coroner. Do not report "Old Age" as the cause of death, but state the primary cause which resulted in death. Be sure that the cause of death is clearly and legibly written. Use only standard abbreviations. Do not use ditto marks. Be sure that the entry in each item is complete. Do not leave any item blank. If unknown, write "unknown." Be sure that the exact age is especially important. Physicians: please write the cause of death clearly and legibly.

G26152 Registered No. G26152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1512 Marshall St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 Marshall St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Langenbach 2/21/45

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 13 1876

8. AGE: Years 69 | Months - | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Welsh
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Kuhl
15. Birthplace Md.

16 (a) Informant Family
(b) Address 1512 Marshall St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 2-24-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave

18 (a) Funeral director Samuel McCurley
(b) Address 3.2. Fred Rd.

19 (a) FEB 23 1945 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1945, at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1945 to Feb 21 1945, and that I last saw h[illegible] alive on Feb 21, 1945.

Immediate cause of death	Duration
Myocardial Insufficiency	1 hour
Due to Arterio Sclerosis	5 yrs
Due to Brights disease	2 yrs
Other Conditions High blood pressure	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ed. L. Zimmerman M. D.
Address 4858 Harford Rd Date signed 2/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 8/a

G26153
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So Balto. Gen Hosp 24 51
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 Beason St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bonnie Jean Cowsill

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race wh | 6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife —

6 (c) If alive, give age 10 Mos

7. Birth date of deceased (mo., day, yr.) Mar 9 1944

8. AGE: Years | Months 11 10 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name James Wm Cowsill
13. Birthplace Ohio

MOTHER 14. Maiden Name Pearl D. Holliday
15. Birthplace Va.

16 (a) Informant James. Wm Cowsill
(b) Address 1421 Beason St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/23/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem
Location A. A. Co

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St.

19 (a) (Date rec'd by registrar) (b) Livingston Williams Registrar

FEB 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22-45, 5:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20/45 to 2/22/45 and that I last saw h[illegible] alive on 2/22/45.

Immediate cause of death	Duration
Pneumonia	
Due to Brain abscess	
Due to Meningitis	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. D. Gassaway M.D.
Address St. Balto Gen Hosp Date signed 2/23/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓97

626154 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2506 Marylandmore
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2506 Md. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary H. Blake

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) ~~Single~~, ~~married~~, widowed, ~~or divorced~~.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13, 1871

8. AGE: Years 73 | Months 5 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Moulton
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret Owens
15. Birthplace Md.

16 (a) Informant Geo. Blake (son
(b) Address 2502 Md Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24, 945 (month) (day) (year)
(c) Cemetery or crematory New Cathederal
Location Baltimore, Md

18 (a) Funeral director E. L. Covington
(b) Address 21 W 25 St. Balto, Md.

19 (a) ... (b) ... Registrar

FEB 23 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20 1945, at 11 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/18 1945 to 2/20 1945 and that I last saw h[illegible] alive on 2/20 1945.

Immediate cause of death	Duration
(a) Pulm. edema (acute)	2 hr.
Due to Hypertension	9 years
Due to Arterio-sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Theodore Cleveland M. D.
Address 1401 Eutaw Place Balto Md
Date signed 2/22/45

VS 150

Please fill in all items, if any, and if none, write none. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓85

626155 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hosp 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 424 N. Carey St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Lily Counselor

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C.	

6 (b) Name of husband or wife.....
6 (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years	Months	Days	If less than one day
35 34			....hr. ....min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Music Teacher
11. Industry or business

FATHER
12. Name Unk
13. Birthplace

MOTHER
14. Maiden Name Mary Young
15. Birthplace Md.

16 (a) Informant Carrie Clark Johnson
(b) Address 808 Edmondson Ave

17 (a) Burial (b) Date thereof 2-21-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location.....

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 (a)..... (Date rec'd by registrar) (b) Huntington Williams Registrar

VS Form FEB 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1945, at 12 5-5 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to.....death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH..... Status Epilepticus, N.T.N.

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb. 16 1945

626156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161C

626156 Registered No.

Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: SBGH 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 Fifth St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl Wojciechowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/18/45

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Wojciechowski
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Helen Glodek
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Helen Wojciechowski
(b) Address 211 Fifth street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 S. Linn street

19 (a) Filed Feb 23 1945 (Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22 1945, at 11:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18 1945 to 2-22 1945 and that I last saw her alive on 2-22 1945.

Immediate cause of death	Duration
Hemorrhagic disease of the newborn	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph S. Ardinger M. D.
Address 1213 Light St. Date signed 2-22-45

G26157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 H

G26157 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Morling Ave (If no street, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Forrest E. Rutherford

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-01-2693

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elsie V. Rutherford

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 5-1905

8. AGE: Years 39 | Months 5 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Martinsburg W. Va. (Town, county, and state)

10. Usual Occupation Crane Operator

11. Industry or business Bethlehem-Fairfield Ship Yard

FATHER
12. Name James Rutherford
13. Birthplace Virginia

MOTHER
14. Maiden Name Belle Kimes
15. Birthplace Virginia

16 (a) Informant Mrs. Elsie V. Rutherford
(b) Address 1415 Morling Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 24. 1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a)..... (b)..... (Date rec'd by registrar) Registrar

FEB 23 1945 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/20 1945, at 11:30 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating Gas

Other Conditions Despondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/20/45 about 10:00 P.M.
(b) Where did injury occur 1415 Morland Ave
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Inhalation of gas fumes

23. Signature [illegible] M.D. Medical Examiner.
Date signed 2/21/45

VS 15B

626138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161C

Registered No. 626138

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3843 Quarry Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME William M. Kemp, Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 5. 1945

8. AGE: Years	Months	Days	If less than one day
—	—	16	hr. ..... min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name William M. Kemp
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Genevieve Brown
15. Birthplace Baltimor Maryland

16 (a) Informant William M. Kemp
(b) Address 3400 Chestnut Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 23-1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Black Rock Road Baltimore Co.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3031 Falls Road

19 (a) FEB 23 1945 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 1945, at 11 15 A. M

21. I certify that I took charge of the remains described above, held an Partial Autopsy and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Hus death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Hemorrhage.

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury.....

23. Signature Howard J. Maldeis M.D. Medical Examiner.
Date signed 2-21-45

626159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

626159 / 469

Registered No. 626159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 W. Saratoga St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4

(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 618 W. Saratoga St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Gray

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex M.

5. Color or race Col.

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-10-1871

8. AGE: Years 73 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Northumberland Co Va (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Joseph Gray
13. Birthplace Va

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Va

16 (a) Informant Martha Baker
(b) Address 618 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Chas. S. Cooper
(b) Address 512 W. Carrollton Ave

19 (a) Filed by registrar (b) Huntington Williams

23 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1945 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1945 to 2-19 1945, and that I last saw h[illegible]live on 2-19 1945.

Immediate cause of death Carcinoma Head of Pancreas — Duration

Due to Metastasis — 6 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 600 Eutaw Pl. Date signed 2/25/45

PRINTING WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G26160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 150

G26160

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4yr 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 N. Caroline St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister M. Celilia OSF

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13, 1904

8. AGE: Years 41 | Months - | Days 19 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Crover
13. Birthplace -

MOTHER 14. Maiden Name Genevieve Ebert
15. Birthplace

16 (a) Informant Sr. M. Pierre
(b) Address St Joseph Hosp

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director R. J. Kirk
(b) Address 530 Hoyt St

19 (a) FEB 23 1945 (Date rec'd by Registrar) Registrar Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21 19 45, at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 19 45, to 2/21 19 45 and that I last saw h[illegible] alive on 2/21 19 45

Immediate cause of death: General Coccidioidomycosis

Due to: [illegible] tuberculous meningitis

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis J. Roth, Jr. M.D.
Address St Joseph's Hosp Date signed 2/23/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 626161

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 2
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 Brunt St (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Robert Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Martha Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-12-1876

8. AGE: Years	Months	Days	If less than one day
68	3	9	hr. min.

9. Birthplace Lynchburg Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Harris
13. Birthplace Lynchburg Va

MOTHER
14. Maiden Name Ruth Abmmngham
15. Birthplace Va

16 (a) Informant Martha Harris
(b) Address 1512 Brunt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md

18 (a) Funeral director Mrs Frances A Hemsley
(b) Address 578 Biddle St

19 (a) FEB 23 1945 (b)
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21 1945, at 2.02 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Hugh V McNally M.D. Medical Examiner.
Date signed 2/22/45

Huntington Williams

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

465877 626162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 626162

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 S. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Novak.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female.	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-14-67.

8. AGE: Years	Months	Days	If less than one day
77	11	8	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Michael Pilachowski
13. Birthplace Poland

MOTHER
14. Maiden Name Josephine ? ?
15. Birthplace Poland

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore Md.

18 (a) Funeral director George A. Weber
(b) Address 705 S. Ann street

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 FEB 23 1945 Huntington Williams Approved by Howard J. Anderling, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 22 1945, at 4.57 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec - 2 1944, to Feb - 22 1945, and that I last saw her alive on Feb 22 1945.

	Duration
Immediate cause of death Fracture of left hip Bronchopneumonia	
Due to Traumatic fracture of left hip + hospitalization in	
Due to old.	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: YES.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 2/2
(b) Date of occurrence Nov. 22, 1944 M
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury Fall

23. Signature J. C. Handelsman M. D.
Address 1111 Date signed 2-23-45

G26163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G26163 Registered No.

Use typewriter, ballpoint pen, or indelible pencil. Physician please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 E. Pratt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 E. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hattie Stevens Stoltzman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 79 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation
11. Industry or business Domestic

FATHER 12. Name Not Known
13. Birthplace

MOTHER 14. Maiden Name Not Known
15. Birthplace

16 (a) Informant William Henson
(b) Address 117 N Chappel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brookland Wd.

18 (a) Funeral director Elroy O Wilson
(b) Address 1510 Orleans St

19 (a) (Date received) (b) FEB 23 1945 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1945, at 10 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular-renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed Feb. 22 1945

(over)

G26164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G26164
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 300 S. Elmwood St. 26

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 S. Elmwood St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Dudek

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26 - 1945

8. AGE: Years | Months: 0 | Days: 28 | If less than one day: — hr. — min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: Infant

FATHER
12. Name: Joseph A. Dudek
13. Birthplace: Md

MOTHER
14. Maiden Name: Bess. Glodek
15. Birthplace: Md

16 (a) Informant: Joseph Dudek
(b) Address: 300 E. Elmwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/22/45 (month) (day) (year)
(c) Cemetery or crematory: St. Stanislaus
Location: Bayview Cem

18 (a) Funeral director: Williams Fiaschetti
(b) Address: 618 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Huntington Ave

VS Form FEB 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1945 at 8½ M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1945 to June 22 1945 and that I last saw h— alive on June 22 1945

Immediate cause of death: Acute Cardiac Dilatation — Duration: 2/21/45
Due to: Bronchopneumonia — 2/20/45
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: William R. Roarer M. D.
Address: 801 Lemmon St Date signed 7/22/45

X

626165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

626165
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hosp. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 Caton avenue
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Finn (THOMAS M. FINN)

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1881

8. AGE: Years 64 | Months 1 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Maurice Finn
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ellenora Logue
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Henry Kleinhenn
(b) Address 405 S. Caton avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans Son, Inc.
(b) Address 118 W. Mt. Royal Ave.

19 (Signature and address of local registrar) FEB 23 1945 Huntington Hollins, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 19 45 at 3:45 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Feb. 21 19 45 to Feb. 21 19 45 and that I last saw him alive on Feb. 21 19 45.

Immediate cause of death	Duration
Pulmonary edema	?
Due to C.A. of larynx	
Due to	
Other Conditions (Include pregnancy within 3 months of death) Myocardial failure (?)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Goldstein
Address Univ. Hosp. Date signed 2/21/45 (M. D.)

Approved. Robert G. Ingham MD 2/23/45

X

G26166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G26166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Harman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary Caffrey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/15/54

8. AGE: Years 90 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Tarrytown Md
(Town, county, and state)

10. Usual Occupation Driver

11. Industry or business

FATHER
12. Name Samuel Harman
13. Birthplace

MOTHER
14. Maiden Name Sarah Fisher
15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (b) Registrar

FEB 23 1945 Huntington Hilldale, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1945, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945, to Feb 22 1945, and that I last saw h~~im~~ alive on Feb 21 1945.

Immediate cause of death	Duration
Edema of Lungs	2 days
Due to Cerebral Hemorrhage	20 days
Due to	
Other Conditions Arterio Sclerosis	5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E. North Ave Date signed Feb 22-45

X

Items of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

LINK

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. G 20167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1810 Jackson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 Jackson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret E. Link

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Daniel C. Link

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) April 14 1880

8. AGE: Years 64 | Months 10 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Emmet Le. Clare

FATHER 13. Birthplace Virginia

MOTHER 14. Maiden Name Ellgid. Dunn

MOTHER 15. Birthplace Virginia

16 (a) Informant Daniel C. Link

16 (b) Address 1810 Jackson St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Feb 24 1945 (month) (day) (year)

17 (c) Cemetery or crematory Cedar Hill

Location Frederick Highway

18 (a) Funeral director Clarke & Sullivan

18 (b) Address 703 McHenry St.

FEB 23 1945 (a) (Date received by Registrar) (b) Huntingtown Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1945 at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1 1944 to 2-21 1945 and that I last saw h[illegible] alive on 2-21 1945

Immediate cause of death	Duration
Carcinoma of Uterus Cervix	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Biopsy at South Balto. Hosp = Carcinoma

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Seelod M. D.

Address 707 E. Fort Ave Date signed 2-23-45

X

PRINT WITH PENCIL, WITH CAPITAL INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93B

26168 Registered No. 26168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1528 E. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1528 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dolores Gattis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1924

8. AGE: Years 20 | Months 11 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Winfield Gattis
13. Birthplace Md.

MOTHER
14. Maiden Name Sarena Maddox
15. Birthplace Md.

16 (a) Informant Sarena Gattis
(b) Address 1528 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 23/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mc Colgan & Elliott Dept.
(b) Address 1297 Caroline St.,

FEB 23 1945 Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1945, at 9:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1945, to Feb 19 1945, and that I last saw h[illegible] alive on Feb 19 1945

Immediate cause of death: Acute Cardiac Dilatation — Duration: 1 day

Due to: Myocarditis — Duration: uncertain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ben Horn M.D. M. D.
Address 707 N Conkling St Date signed Feb 24, 1945

VS 150

626169

YA-92176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

Registered No. 626169

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard E Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. ~~Divorced~~ Widower

6 (b) Name of husband or wife Mary Louise Hill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1869

8. AGE: Years 75 | Months 2 | Days 16 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry Hill (d)
13. Birthplace Pa.

MOTHER
14. Maiden Name Sally Evans
15. Birthplace England

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn, A.A.Co., Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) FEB 23 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21, 1945, at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17, 1945 to Feb. 21, 1945, and that I last saw him alive on Feb. 21, 1945.

	Duration
Immediate cause of death: Heart Failure	2 mo
Due to: Toxemia-injection & uremia	3 wks
Due to: Urinary obstruction	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2-19-45

Major findings of operation: Unchecked Stricture - thinning of urethra

of autopsy: Severe Pyelonephritis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E J Perry M D

Address BCH Date signed 2-27-45

VS 150

X

G26170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74B

Registered No. G26170

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Villa Nova (If outside city or town limits, write RURAL and give town)
(d) Street No. Buckingham Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Thomas Juelg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1942

8. AGE: Years	Months	Days	If less than one day
2	9	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Carl W. Juelg
13. Birthplace Washington, D. C.

MOTHER
14. Maiden Name Katherine A. Hoffman
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Carl W. Juelg
(b) Address Buckingham Rd., Villa Nova

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller & Lamoreau
(b) Address 4520 Liberty Heights Ave.

19 (a) FEB 23 1945 (Date received by Registrar) (b) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22 1945, at 2:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/8 1945, to 2/22 1945, and that I last saw h[illegible] alive on 2/22 1945.

Immediate cause of death	Duration
A leukemic Leukemia	1 month
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard C. Hayden M. D.
Address Bon Secours Date signed 2/24/45

VS 130

626171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

626171
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Pier 6, Locust Pt. Baltimore
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town Quincy
(If outside city or town limits, write RURAL and give town)
(d) Street No. 69 Arnold st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald A Ash

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/29/22.

8. AGE: Years	Months	Days	If less than one day
22	7	19	hr. min.

9. Birthplace Mass.
(Town, county, and state)

10. Usual Occupation Cox Wain

11. Industry or business U. S. Navy

FATHER
12. Name William Ash.
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant U. S. Navy
(b) Address Balto, + Commerce st

17 (a) Burial (b) Date thereof 2/27/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Quincy, Mass.

18 (a) Funeral director A. Lee Oder
(b) Address 4644 York Rd.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

FEB 23 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1945, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: ? ? 24/1

(a) Date of injury at M.
(b) Where did injury occur? Pier #6 Locust St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? Yes
(d) Means of injury Found drowned

23. Signature Robert Le Fratar M.D.
Medical Examiner.
Date signed Feb 19 1945

Huntington Williams M.D.

Katie E

G26172 X 93D ✓ G26172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home + Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Holetharpe
(If outside city or town limits, write RURAL and give town)
(d) Street No. 45 10 Poplar Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Katie E. Wengel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mr. Ernest A Wengel

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) July 6 1872

8. AGE: Years 72 | Months 7 8 | Days 17 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Frederick G Schuchmann

13. Birthplace Germany

MOTHER 14. Maiden Name Katherine Greatenman

15. Birthplace Germany

16 (a) Informant Mrs. J. T Fairfall

(b) Address 3208 Brighton St City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26 1945 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location City

18 (a) Funeral director Mrs. John W. Fawsett + Son

(b) Address 801 W. Fayette St.

19 (a) FEB 23 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1945 at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1945 to Feb 23 1945 and that I last saw her alive on Feb 22 1945

Immediate cause of death: Lt + Rt sided heart failure — Duration: 2 weeks

Due to: Hypertensive cardio-vascular disease — Duration: yrs

Due to:

Other Conditions: Uremia, umbilical hernia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marvin W. Darsie M. D.

Address Church Home Date signed 2-23-45

X

G26173

BALTIMORE CITY HEALTH DEPARTMENT ✓ 107

CERTIFICATE OF DEATH

G26173 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md.? (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 101 Shields Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred A. Bartlett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-5-1902

8. AGE: Years	Months	Days	If less than one day
42	9	16	hr. min.

9. Birthplace Pottsville, Pa. (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Wm. L. Bartlett
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary A. Murphy
15. Birthplace Pa.

16 (a) Informant Wm. H. Bartlett
(b) Address 809 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania ave

Feb 23 1945 Huntington Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1945, at 12 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Feb. 21 1945

VS 151

Use ribbon to write the causes of death clearly and legibly. Typewriting preferred. Please write the name of the deceased on the back of this certificate.

G26174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

G26174
Registered No.

CWK 92145

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 803 N. Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Isaac Hicks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) x April 2-1881

8. AGE: Years	Months	Days	If less than one day
63	10	13 17	hr. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Isaac Hicks
13. Birthplace Maryland

MOTHER
14. Maiden Name Sydney Gray
15. Birthplace Maryland

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 2/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Balto. County

18 (a) Funeral director Byron & Mamie Wright
(b) Address 701 Asquith St.

19 (a) 1945 (b) Huntington Williams M.D.
(Registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1945, at 12:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1945, to Feb. 19 1945, and that I last saw him alive on Feb. 18 1945.

Immediate cause of death	Duration
Cerebral infarct	
Bronchopneumonia	
Due to	
Due to	
Other Conditions Generalized osteosclerosis Pulmonary emphysema	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Kornblum M. D.
Address Baltimore City Hospitals Date signed 2-22-45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G26175

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

77D

Registered No. G26175

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mdn (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 224 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Howard Palmer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Marie B. Palmer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1911

8. AGE: Years 33 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business

FATHER
12. Name Clem Palmer.
13. Birthplace Virginia

MOTHER
14. Maiden Name
15. Birthplace Virginia

16 (a) Informant Mrs. Maggie Bolden
(b) Address 31 N. Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 23, '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

FEB 23 1945 (Date rec'd by registrar) (b) Kentucky Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20-[illegible] 1945 at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1945 to 2-20 1945 and that I last saw him alive on 2-20 1945

Immediate cause of death Pulmonary edema — Duration 3 hrs

Due to Cardiac failure

Due to Alcoholic toxemia — Duration 15 days

Other Conditions Delirium tremens, pemberton edema, nitrogen retention

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: Pulmonary, hepatic congestion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. F. Gleason M. D.
Address Univ. Hosp. Date signed 2-21-45

VS 150

X

626176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

Registered No. 626176

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6313 S. Boston ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) 14 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6313 S. Boston ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Beecraft

3 (b) If veteran, name war: World War

3 (c) Social Security Account No. 400-07-8689

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	married

6 (b) Name of husband or wife: Pearl B.

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Dec 10 1895

8. AGE: Years	Months	Days	If less than one day
49	2	11	hr. min.

9. Birthplace Mt Sterling Kentucky
(Town, county, and state)

10. Usual Occupation Guard a Camp

11. Industry or business Hotel

FATHER
12. Name Wm. Beecraft
13. Birthplace Kentucky

MOTHER
14. Maiden Name Cordelia Sublett
15. Birthplace Round County Kentucky

16 (a) Informant Wife
(b) Address

17 (a) Burial (b) Date thereof 2/26/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory National Cemetery
Location Frederick Rd.

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

19 (a) Filed FEB 23 1945 (b)
(Date rec'd by local reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1945, at 6P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fraker M.D.
Medical Examiner
Date signed Feb. 22 1945

Huntington Williams Md.

VS 151

G26177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

114E

Registered No. G26177

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fairmont & N. Broadway.
(c) Hospital or institution:
Church Home & Hospital. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 12 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore.
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 S Highland Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Tillinghast

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-22-45

8. AGE: Years	Months	Days	If less than one day
			11 hr. 7 min.

9. Birthplace Baltimore (Balto Co.) Md
(Town, county, and state)

10. Usual Occupation Infant.

11. Industry or business

FATHER
12. Name Mr. Morgan B. Tillinghast
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mrs Mary Tillinghast
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Mary Tillinghast
(b) Address 100 S Highland Ave, Balt. Md

17 (a) Home Burial (b) Date thereof 2/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd

18 (a) Funeral director Selby & Sons Inc
(b) Address 402 E Lexington St

19 (a) FEB 23 1945 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1945, at 1 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22 1945, to 2-23 1945, and that I last saw h/m alive on 2-23 1945.

	Duration
Immediate cause of death Atelectasis of lungs - bilateral.	11 hrs
Due to Obstruction of bronchi	11 hrs.
Due to Aspiration of mucous.	11 hrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Steuart Hatch, M. D.
Address Church Home Hospital Date signed 2-23-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G26178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G26178 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 215 S. CONKLING ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 62 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 S. CONKLING ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY A. MACKLIN

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: MICHAEL MACKLIN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 2 1880

8. AGE: Years 64 | Months 5 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name THOMAS BLUM
13. Birthplace GERMANY

MOTHER
14. Maiden Name FRANCES BURKHARDT
15. Birthplace GERMANY

16 (a) Informant MARY CUOMO (DAUGHTER)
(b) Address 215 S. CONKLING ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 26/45 (month) (day) (year)
(c) Cemetery or crematory ST. STANASLAUS
Location DUNDALK AVE.

18 (a) Funeral director Lilly and Geller INC.
(b) Address 493 S. WOLFE ST.

19 (a) FEB 23 1945 (Date rec'd by registrar) Huntington Hilligan Registrar

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH FEB. 21 1945, at 10/15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to 2/21 1945.
and that I last saw her alive on 2/17 1945.

Immediate cause of death Coronary Occlusion

Due to Hypertension and C-V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas F. Cuomo M. D.
Address 2215 Eutaw Pl Date signed 2/22/45

Charles Flom

VS 150

Please answer all questions. Entry should be carefully supplied from the records. Any item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓ Registered No. 626173

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4631 Belmont Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4631 Belmont Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Jeanne Rand.

3 (b) If veteran, name war	3 (c) Social Security Account No.
–	–

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widow

6 (b) Name of husband or wife George E. Rand.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 2, 1878.

8. AGE: Years	Months	Days	If less than one day
66 67	11	19	hr. min.

9. Birthplace London, England
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace Unknown

MOTHER
14. Maiden Name Jones.
15. Birthplace Unknown

16 (a) Informant Edward Rand.
(b) Address 4631 Belmont Road.

17 (a) Burial, (b) Date thereof 2-24-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Walter R. McNamee,
(b) Address 4114 Falls Road

19 (a) FEB 23 1945 Huntington Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1945, at 11P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940, to 2/21 1945, and that I last saw h[er] alive on 2/21 1945.

Immediate cause of death	Duration
Myocarditis	years
Due to Arteria-Sclerosis Generalized	years.
Due to	
Other Conditions Lobar Pneumonia (Include pregnancy within 3 months of death)	one week.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hampton Hamm M. D.
Address 20 E. Preston St. Date signed 2/23/45

VS 2

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

626180 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 959 N. Washington St.
(c) Hospital or institution:

7-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 959 N. Washington Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James John Nemec, Sr.

21

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Antonie (nee Janata
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1870

8. AGE: Years	Months	Days	If less than one day
74 yrs.	5	14	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name John Nemec
13. Birthplace Czech.

MOTHER
14. Maiden Name Unknown
15. Birthplace Czech.

16 (a) Informant James J. Nemec, Jr. (son)
(b) Address 959 N. Washington St.,

17 (a) Burial (b) Date thereof 2/24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or [redacted] Oak Hill
Location Baltimore Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) FEB 23 1945 (Date received by Registrar) Huntington Ave.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1945, at 7:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1945, to Feb 21 1945, and that I last saw h[redacted] alive on Feb 21 1945

Immediate cause of death	Duration
Hydrothorax Pneumonia	2/19/45
Due to	
Due to Carcinoma of Liver	7/1944
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Nemec
Address 801 S Kenwood Ave Date signed 2/24/45

VS 150

X

PRESS WHITE LETTERS, WITH UNFADING INK. Every item of information should be carefully supplied. Where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

626181 Registered No.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3202 Elgin Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3202 Elgin Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: EDWARD ROY ADAMS

3 (b) If veteran, name war: none

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Florence Walker Adams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1876

8. AGE: Years 68 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace: Richmond, Ind. (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Hess Co.

FATHER
12. Name Judson Adams
13. Birthplace Ohio

MOTHER
14. Maiden Name Isabella Bateman
15. Birthplace England

16 (a) Informant Miss Serena B. Adams
(b) Address 3202 Elgin Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER &SONS
(b) Address Balto., Md.

19 (a) (b) Registrar

FEB 23 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1945, at 9.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1945 to Feb 21 1945 and that I last saw him alive on Feb 21 1945.

Immediate cause of death: Bronchial Pneumonia — Duration 48 hrs

Due to: Cerebral Sclerosis — about 18 Mo

Due to: — over

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: X X

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: X X X
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: P. L. Kyser M. D.
Address Westminster, Md. Date signed 2-25-45

X

G26182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G26182

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and 32nd Sts.
(c) Hospital or institution: The Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore County
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 7 Willow Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Thomas Peterson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of ~~husband or~~ wife Mary F. Peterson

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March ?, 1878

8. AGE: Years 66 | Months 11 | Days ? | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore County, Maryland (Town, county, and state)

10. Usual Occupation Rural Mail Carrier

11. Industry or business Retired

FATHER 12. Name Charles Thomas Peterson

FATHER 13. Birthplace ?

MOTHER 14. Maiden Name ?

MOTHER 15. Birthplace

16 (a) Informant Hospital Records

(b) Address Union Memorial Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 25 1945 (month) (day) (year)

(c) Cemetery or crematory Providence Cem.

Location Providence, Balto. Co., Md.

18 (a) Funeral director John Burns Sons

(b) Address Towson, Md.

19 (a) FEB 23 1945 (Date rec'd by registrar) Hampton Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1945, at 11:59 PM

21. I certify that death occurred on the date above stated; that I attended deceased from February 21, 1945 to February 22, 1945, and that I last saw him alive on February 22 1945

	Duration
Immediate cause of death: Cardio-respiratory Failure	
Due to: Cerebrovascular accident	24 hours
Due to: Arteriosclerotic Cardiovascular Disease	
Other Conditions: Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, III M. D.

Address Union Memorial Hospital Date signed 2/23/45

620.103 ✓ 620.103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 154 N. Lakewood Ave.
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME William Zander

3 (b) If veteran, name war ——

3 (c) Social Security Account No. 247-05-0154

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary M Zander
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) June 24 1888

8. AGE: Years	Months	Days	If less than one day
57	7	27	.....hr. .....min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Marketmis Commission
11. Industry or business

FATHER
12. Name Christoph Zander
13. Birthplace Germany

MOTHER
14. Maiden Name Fredericka Krauser
15. Birthplace Germany

16 (a) Informant Wm F Zander Jr
(b) Address 1578 Lakewood

17 (a) Burial (b) Date thereof 2/24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodland Hills Park
Location Rural

18 (a) Funeral director Wilson Funeral Home
(b) Address 2014 E. Baltimore St.

19 (a) Filed by registrar (b) .....
Registrar

FEB 23 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21, 1945, at 12:30 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Compound Fracture of Back; Rupture of Liver, pancreas & kidneys

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 2/3

(a) Date of injury 2-21-45 at 11:45 A. M.
(b) Where did injury occur? Foot of Broadway. Pier 7 - Locust Point.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes.
(d) Means of injury Fell on Guide rope on pulley broke + fell

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed February 21, 1945.

G26184 — 93D — G26184

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W 40th St
(c) Hospital or institution: Home for Incurables - 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 3/4 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W 40th St
(If rural give location)
(e) Citizen of foreign country? Md (Yes or No)
If yes, name country

3 (a) FULL NAME Miss. Louise Rustebeg

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1875

8. AGE: Years	Months	Days	If less than one day
69	6	26	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name George Rustebeg
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Kropp
15. Birthplace Germany.

16 (a) Informant Mrs. Waters
(b) Address 700 W 40th St

17 (a) Burial (b) Date thereof 2/24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore City
Location

18 (a) Funeral director Sollitt Funeral Home
(b) Address 2004 E Oliver St

19 (a) FEB 23 1945 (b) Registrar
(Date rec'd by registrar)

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 20 1945, at 11:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1938, to Feb. 21 1945, and that I last saw her alive on Feb. 19 1945.

Immediate cause of death	Duration 20-30 mins.
(a) Acute myocardial insufficiency	
Due to: Hypertension & Atherosclerotic Cardiovascular Disease	Several Years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Conrad Will M. D.
Address 11 E. Chase St. Baltimore, Md. Date signed 2/24/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 31a

Registered No. G26185

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 S Grundy St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 S Grundy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Theodore Tietje

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-5861

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Paula Tietje

6 (c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.) July 15 1900

8. AGE: Years: 44 | Months: 7 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business: Machinist

FATHER
12. Name: Nicholas Tietje
13. Birthplace: Germany

MOTHER
14. Maiden Name: Dorothea
15. Birthplace: Germany

16 (a) Informant: Paula Tietje
(b). Address: 618 S Grundy St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/45 (month) (day) (year)
(c) Cemetery or crematory: Trinity Cemetery
Location: City

18 (a) Funeral director: Wm. H. Kemp Funeral Home
(b) Address: 2004 E. Orleans St.

19 (a) FEB 23 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21/ 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1944 to Feb 21 1945.
and that I last saw h[illegible] alive on Feb 21 19[illegible]

Immediate cause of death: Cardio-renal Dis. — Duration: 2 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Thos E. Wilson M. D.
Address: 3 W. Biddle Date signed 2-27-45

VS 150

PRINT OR WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

626186 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 145 N. Wolfe Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 145 N. Wolfe Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE MINNOSSI

3 (b) If veteran, name war

3 (c) Social Security Account No. 261-22-0578

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1921

8. AGE: Years	Months	Days	If less than one day
24			hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Cab Driver
11. Industry or business

FATHER
12. Name Michael Minossi
13. Birthplace Italy

MOTHER
14. Maiden Name Florence Amorosa
15. Birthplace Italy

16 (a) Informant Talbot Terrace
(b) Address 149 N. Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4400 Belair Road

18 (a) Funeral director Joseph Farace Inc.
(b) Address 2013 Fremont Ave

19 (a) (Date received by Registrar) FEB 28 1945 (b) Registrar Huntington Howell M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21, 1945, at 12:45 A M

21. I certify that I took charge of the remains described above, held an INSPECTION Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was ~~primary~~ ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-20-45 at 11:45 P. M. 6/4
(b) Where did injury occur? 145 N. Wolfe Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Inhaled gas from defective heater

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 2/23/45

626187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

626187 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 LAKE DRIVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 60 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 721 LAKE DRIVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** RACHAEL GOODMAN

3 (b) If veteran, name war ~ | 3 (c) Social Security Account No. ~

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced WIDOW

6 (b) Name of husband or wife SAAC

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1850

8. AGE: Years 95 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name DAVID

13. Birthplace RUSSIA

MOTHER 14. Maiden Name FANNIE

15. Birthplace RUSSIA

16 (a) Informant FAMILY RECORDS

(b) Address

17 (a) BURIAL (b) Date thereof 2-25-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory HEBREW FRIENDSHIP

Location BALTIMORE ST

18 (a) Funeral director JACK LEWIS INC

(b) Address 1439 E. BALTO. ST

19 (a) FEB 22 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22-45 19..., at 4P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/6 1922 to Feb 22, 1945 and that I last saw her alive on Feb 22, 1945

Immediate cause of death	Duration
Senility & Arteriosclerosis	10 yrs
Due to Chronic Myocarditis	1 "
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. B. Lewis
Address 211 W. Monument St Date signed 2/28/45

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 626183

626183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green Spring & Belvedere
(c) Hospital or institution:
LEVINDALE
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Green Spring & Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Dina Slotkowsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Max Slotkowsky

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 80 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Murrja -
13. Birthplace Russia

MOTHER 14. Maiden Name Sadona
15. Birthplace Russia

16 (a) Informant Rosa Slotkowsky
(b) Address 2020 N. Bentalou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-45 (month) (day) (year)
(c) Cemetery or crematory Helgew Russdale
Location

18 (a) Funeral director Jos Lewis Inc
(b) Address 1439 E. Balto. St

19 (a) (Date received by local registrar) FEB 23 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1945, at 6.35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8 1936, to 2-23 1945, and that I last saw h[illegible] alive on 2-23 1945.

Immediate cause of death Cerebral haemorrhage
Due to Hypertension, arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration 2-17-45

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Edmund Kern
Address Levindale Date signed 2/25/45

Huntington Williams, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

57 Trans G26189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G26189 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green + Redwood St
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 Mt. Holly St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Bohne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1887

8. AGE: Years 57 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Henry Bohne
13. Birthplace Germany

MOTHER
14. Maiden Name Louise P. Fenning
15. Birthplace Maryland

16 (a) Informant Mrs. George Stenner
(b) Address 421 Mt Holly St

17 (a) Burial (b) Date thereof 2-24-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto.
Location Balto. Md

18 (a) Funeral director Harry A. Wiltse
(b) Address 4101 Edmondson Ave.

19 (a) Date received (Registrar) 2 23 1945 (b) Registrar Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21 1945, at 4:15 P.M.

21. I certify that I took charge of the remains described above, held an Inquest-Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. P. Sabinske M.D.
Medical Examiner.
Date signed 2/21/45

Please write the causes of death clearly and legibly. Physicians: please write the cause in question especially important.

6190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

626190
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address:
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 days

15 18

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2643 W. North Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Schorr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 18, 1945

8. AGE: Years	Months	Days	If less than one day
		19	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Roy W. Schorr
13. Birthplace Maryland

MOTHER
14. Maiden Name Elvina Grupp
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 23 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 23 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1945, at 7:50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 18 1945, to Feb. 6 1945, and that I last saw him alive on Feb. 6 1945.

Immediate cause of death	Duration
Prematurity	
? Aspiration pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. S. Griffith M. D.
Address Johns Hopkins Hospital Date signed 2-9-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 160

2532

X

626191 BALTIMORE CITY HEALTH DEPARTMENT ✓ 626191

CERTIFICATE OF DEATH 170 C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 Aisquith ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy Henry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	M

6 (b) Name of husband or wife Married

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/10/96

8. AGE: Years	Months	Days	If less than one day
49	-	13	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Thaddeus Henry

13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth Johnson

15. Birthplace

16 (a) Informant Marie Henry

(b) Address 704 Sterling St

17 (a) Burial (b) Date thereof 2-26-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvery

Location

18 (a) Funeral director Elroy A. Wilson

(b) Address 1000 Bransley Ave

19 (a) FEB 23 1945 (b) Katherine Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23rd 1945, at 1 15 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Generalized Peritonitis

Due to Fracture of Pelvis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Feb 10 at 1945 10/1/30 P M.

(b) Where did injury occur? Edson ST near Eager

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no

(d) Means of injury Pedestrian struck by auto

23. Signature Robert C. Graham M.D.
Medical Examiner.

Date signed Feb 23 1945

VS 151

G26192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G26192
Registered No.

CMK 90155

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) - 4 15
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 N. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Willie Fair

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Vera Fair

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15-1893

8. AGE: Years 51 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Florida
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jerry Fair
13. Birthplace Florida

MOTHER
14. Maiden Name Mary Thompson
15. Birthplace Florida

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 3-26-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elgar O. Wilson
(b) Address 1900 Bruckland Ave

FEB 23 1945
(Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1945, at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9-44 19 to 2-22-45 19 45
and that I last saw him alive on 2-22 19 45

Immediate cause of death	Duration
Pulmonary Tuberculosis	Years 7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lucius Edwards M. D.
Address Baltimore Md. Date signed 2-23-45

Registrar Williams, M.D.

VS 150

correct age is especially important. Physicians: please write th

26193 clinic

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G26193

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or Institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2215 Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) no.
If yes, name country

3 (a) FULL NAME Baby Turner No II

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-21-45

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Balto. md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Arleveston Turner
13. Birthplace South Wells N. C.

MOTHER 14. Maiden Name Mildred Bailey
15. Birthplace Nandua Va

16 (a) Informant Mildred Turner
(b) Address 2215 Pennsylvania Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL FEB 23 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 23 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21 1945, at 6 50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-19 1945, to 2-21-1945, and that I last saw h[illegible] alive on 2-21 1945.

Immediate cause of death	Duration
Due to Prematurity	5 hrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. Louise Jones M. D.
Address 1100 Druid Hill Ave Date signed 2/22/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

2534

X

626194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

626194 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: President Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Clarence Flood Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-27-45

8. AGE: Years	Months	Days	If less than one day
		17	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick Clarence Flood
13. Birthplace Roanoke Va.

MOTHER
14. Maiden Name Curtistine Kelley
15. Birthplace Carthage N.C.

16 (a) Informant Curtistine Flood
(b) Address 1833 Penna. Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL FEB 23 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 23 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13 1945, at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-27-1945 to 2-13-1945, and that I last saw him alive on 2-12-1945.

Immediate cause of death Prematurity — Duration 17 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carson C. Johnson M. D.
Address 1802 Penna Ave Date signed 2/15/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

12533

G26195 — BALTIMORE CITY HEALTH DEPARTMENT — Seguin — G26195

CERTIFICATE OF DEATH

√54B — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4814 W. Fredrick ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Seguin (SEGUIN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-6-91

8. AGE: Years	Months	Days	If less than one day
53	6	17	hr. min.

9. Birthplace Canada.
(Town, county, and state)

10. Usual Occupation accountant

11. Industry or business

FATHER
12. Name Harry R. Seguin
13. Birthplace Canada.

MOTHER
14. Maiden Name Ada G. Webber
15. Birthplace Canada.

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2/26/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rockville
Location Rockville, Md.

18 (a) Funeral director Wm. Reuben Smythe
(b) Address Rockville Md.

19 (a) FEB 23 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15 1945 to 2-23 1945, and that I last saw h. alive on 2-23 1945

Immediate cause of death — Brain tumor? — post & parasitive — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/20/45

Major findings of operation: Brain tumor? - Frontal

of autopsy Cerebral tumor here.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Guy Crawford
Address Johns Hopkins Hospital Signed 3/23/45

over

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Dr. Golly

G26196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G26196 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5108 Richard Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5108 Richard Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret M. Thieman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife William F. Thieman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1891

8. AGE: Years	Months	Days	If less than one day
53	9	4	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Jerome P. Murphy
13. Birthplace ?

MOTHER
14. Maiden Name Mary Jane Mc Clemen
15. Birthplace Balto. Md.

16 (a) Informant Mr. William F. Thieman
(b) Address 5108 Richard Avenue

17 (a) Bruial (Burial, cremation, or removal) (b) Date thereof 2/24/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

FEB 23 1945 (Date rec'd by registrar) (b) Registrar Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 1945, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20th 1945, to Feb 21 1945, and that I last saw her alive on Feb 21 1945.

	Duration
Immediate cause of death Respiratory failure	7 hrs.
Due to Cerebro-vascular accident Hemorrhage	7 hrs
Due to Hypertension Cardiovascular disease	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Z Berry M. D.
Address Mercy Hospital Date signed 2/26/45

X

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

626197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

626197

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline ST.
(c) Hospital or institution:
St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto,
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2132 Willow Spring Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Martha A. Simmons (SIMMONS)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife M. K. Simmons
6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) June 10-1872

8. AGE: Years 72 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Henry Mullinax
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Carl Hall
(b) Address 2182 Willow Sp. Rd Randall

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-45 (month) (day) (year)
(c) Cemetery or crematory
Location Staunton, Va.

18 (a) Funeral director John S. Connelly
(b) Address 418 Eastern Ave. Lindy

19 (a) [illegible] (b) Huntington Williams W.V.
(Signature of registrar)

FEB 24 1945

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23 1945, at 2 09 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22 1945, to 2-23 1945, and that I last saw her alive on 2-25 1945.

Immediate cause of death Cardiac Failure — Duration

Due to Chronic Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M E Robertson M. D.
Address St. Josephs Hosp. Date signed 2-23-45

X

626198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

626198 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully compiled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2868 Pelham Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2868 Pelham Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John E. Weitzel
3 (b) If veteran, ... war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1907

8. AGE: Years	Months	Days	If less than one day
37	7	12	... hr. ... min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Garage Prop.
11. Industry or business

FATHER
12. Name Edward W. Weitzel
13. Birthplace Balto.

MOTHER
14. Maiden Name Katherine Binder
15. Birthplace Phila.

16 (a) Informant Edward W. Weitzel
(b) Address 1613 E. 33rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director John A. Miller
(b) Address 1105-1107 E. Jefferson st
19 (a) Filed FEB 24 1945 (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1945, at 2 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1944, to Feb 17th 1945, and that I last saw h... alive on Feb 17th 1945;

Immediate cause of death Coronary Occlusion — Duration

Due to Hypertension — 2.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H-J Taubman M. D.
Address 100 N. Milton Ave Date signed 2/23/45

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6/26199 / 126 / 6/26199

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins & Catonsville Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Louttsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eppa Ahalt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bessie C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day hr.	min.
66				

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation farmer
11. Industry or business

FATHER
12. Name Carlton E. Ahalt
13. Birthplace Virginia

MOTHER
14. Maiden Name Sarah Custerman
15. Birthplace Md.

16 (a) Informant James W. Ahalt
(b) Address Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26 (month) (day) (year)
(c) Cemetery or crematory Lutheran
Location Louttsville Va.

18 (a) Funeral director C. H. Zepp & Bro
(b) Address Brunswick Md

FEB 24 1945 (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23/45, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/26 19 45 to 2/23 19 45
and that I last saw h/ alive on 2/23 19 45

Immediate cause of death Heart Failure

Due to Myocardial Heart Disease

Due to Myocarditis

Other Conditions Chole lithiasis

(Include pregnancy within 3 months of death)

Date of operation 2/17 Chole lithotomy

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard W. Stier M. D.
Address St Agnes Hospital Date signed 2/23/45

VS 150

Formerly Health Department, Vital Statistics Bureau, Room 104, City Hall. Every question must be answered. Please write correct age in years, months, days. If less than one day, give hours or minutes. Give usual occupation of each person, even if retired or housewife. Give causes of death clearly and legibly. correct age is especially important. Physicians: please write the cau

G66200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G66200

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2024 Harford Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2024 Harford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CIACOMINO JACK D'ANGELO

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Rose D'Angelo
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 11, 1878
8. AGE: Years 67 | Months 0 | Days 10 | If less than one day: hr. min.
9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Cement Finisher
11. Industry or business

FATHER
12. Name Salvatore D'Angelo
13. Birthplace Italy

MOTHER
14. Maiden Name ? Antoinette Culotta
15. Birthplace ? Italy

16 (a) Informant Mr. Raymond D'Angelo
(b) Address 2024 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

FEB 24 1945 (Date rec'd by local registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 10 1944 to Feb 21 1945, and that I last saw him alive on Feb 20 1945.

Immediate cause of death: Carcinoma of Liver — Duration
Due to: Metastases
Due to:
Other Conditions: Gastric Cancer
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Lucy Fiaba M. D.
Address 1023 N. Bond St Date signed 2/28/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6 26201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92c

Registered No. 26201

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: Univ. Hosp 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4907 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Norman Winter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband~~ or wife Genevive

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 30th 1906

8. AGE: Years 38 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Cab driver

11. Industry Private Family

FATHER
12. Name Earnest Winter
13. Birthplace Md

MOTHER
14. Maiden Name Mary A. Kegler
15. Birthplace Md.

16 (a) Informant William Tierney
(b) Address 721 Highwood Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/45 (month) (day) (year)
(c) Cemetery Maryland Park
Location Parkville Md

18 (a) Funeral director William Cook Inc
(b) Address 1219 St Paul St

19 (a) FEB 24 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 23 1945 at 10 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15 1945 to 2-23 1945 and that I last saw him alive on 2-23 1945.

Immediate cause of death	Duration
Rheumatic - Cardio Vascular Disease	
Due to Stenosis & Insuff Aortic Valve	
Due to Cardiac Failure & Hypertrophy	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Stenosis Aortic Valve

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Faulkner Brown M.D. M. D.
Address Redwood & Green Univ Hosp Date signed 2-23-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 626202

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Parkville (If outside city or town limits, write RURAL and give town)
(d) Street No. Shepphard Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Margaret M. Huff
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Joseph A. Huff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5th 1900

8. AGE: Years	Months	Days	If less than one day
44	9	17	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Will Novitz
13. Birthplace Unknown

MOTHER
14. Maiden Name " Mintz
15. Birthplace "

16 (a) Informant Joseph A. Huff
(b) Address Shephard Ave. - Parkville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

(b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar) FEB 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1945, at 10:56 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 21 1945, to Feb 22 1945, and that I last saw her alive on Feb 22 1945.

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Hemorrhage	24hrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roy Bygon Turner, Jr. M. D.
Address Mercy Hospital Date signed 2/22/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G26203

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4218 Bayonne Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4218 Bayonne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Kress

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or~~ wife Edna Kress

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 1st 1860

8. AGE: Years 84 | Months 11 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Florist

11. Industry or business Own Business

FATHER
12. Name Nicholas Kress
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown)
15. Birthplace "

16 (a) Informant George Kress
(b) Address 4305 Frankford Ave

17 (a) Burial (b) Date thereof 2/26/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery or ~~crematory~~ Balto.
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1219 St. Paul st

19 (a) FEB 24 1945 (b) Huntington Williams MD
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22nd 1945, at 4 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945, to Feb 22 1945, and that I last saw ~~him~~ her alive on Feb 21 1945.

Immediate cause of death: Chronic myocarditis — Duration

Due to arterio sclerosis

Due to

Other Conditions senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry A Anderson M. D.
Address 3001 Shannon Drive
Date signed Feb 22 45

G66204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

136

Registered No. G66204

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1335 W North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1335 W North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary O. Byrne

3 (b) If veteran, name war: No
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Christopher H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 4, 1888

8. AGE: Years	Months	Days	If less than one day
56	5	19	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Harry E Mitchell
13. Birthplace

MOTHER
14. Maiden Name Sarah McCann
15. Birthplace

16 (a) Informant Christopher Byrne
(b) Address 1335 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/45 (month) (day) (year)

(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Fullerton & Son
(b) Address 1717 Pont St

FEB 24 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1945, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1945 to Feb 22 1945, and that I last saw her alive on Feb 11 1945.

Immediate cause of death: General Tuberculosis — Duration: Several years

Due to: Pulmonary

Due to: Intestinal

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Keown

Address 1938 Linden Ave Date signed 2/26/45 M. D.

Record

PLEASE WRITE PLAINLY, with INK and DO NOT ABBREVIATE. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

626205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

626205 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Darling

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Harry E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26 1869

8. AGE: Years 75 | Months 5 | Days 27 | If less than one day hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George Sweetser
13. Birthplace Pa

MOTHER
14. Maiden Name Mahala Sondborn
15. Birthplace Mass

16 (a) Informant A Virginia Savage
(b) Address 2211 Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/45 (month) (day) (year)
(c) Cemetery or crematory Pinkerton Home
Location Grmy & Baltimore

18 (a) Funeral director Wilson & Cook Inc
(b) Address 219 N Fort St

19 (a) FEB 24 1945 (Date received by Registrar) Funeralizer for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1945 at 1 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1942 to Feb 21 1945. and that I last saw h[illegible] alive on Feb 21 1945

	Duration
Immediate cause of death Cerebral Hemorrhage	2 hours
Due to Arteriosclerosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Arthur J Davis M. D.
Address 800 N Eutaw St Date signed 2-22-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Register No. 6226206 / 477

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3332 Mc Elderry St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3332 Mc Elderry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Edvard Norgren

3 (b) If veteran, name war W
3 (c) Social Security Account No. x

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Dagny

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1887

8. AGE: Years 57 | Months 3 | Days - | If less than one day hr. min.

9. Birthplace Sweden (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name Jonas Norgren
13. Birthplace Sweden

MOTHER 14. Maiden Name Anna (Unknown)
15. Birthplace Sweden

16 (a) Informant Dagny Norgren
(b) Address 3332 Mc Elderry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md

18 (a) Funeral director Wilson & Goulet
(b) Address 1217 E. Oulet St

Filed FEB 24 1945 (Date received by local registrar) Waiting for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1945, at 89 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2, 1945, to Feb. 21, 1945.
and that I last saw h im alive on Feb. 20, 1945

Immediate cause of death: Carcinoma of the lungs with Metastasis.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 1 year

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore Antignani M.D.
Address 2942 E. Fayette St. Date signed 2/21/45

X

G26207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G26207

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1947 E. 31st St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1947 E. 31st St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maria L. Rack.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Wm. Rack
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 1858

8. AGE: Years 86 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Germany.
(Town, county and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Weber
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Mr. Tom Rack
(b) Address 1947 E 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 24, 45 (month) (day) (year)
(c) Cemetery or crematory Lynnwood
Location Gwinn Oak

18 (a) Funeral director L. Heemann & Son
(b) Address 32 S. Broadway

19 (a) FEB 24 1945 (b) Signature Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24, 1945, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 21 1945 to Feb 24 1945, and that I last saw h[illegible] alive on Feb 21 1945.

Immediate cause of death Arteriosclerosis — Duration 5 yrs
Due to
Due to
Other Conditions Fractured Femur (Left) — 3 wks
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9/6
(a) Accident, suicide, or homicide Fractured Femur
(b) Date of occurrence Feb. 21/45 at 4 P. M
(c) Where did injury occur? Baltimore (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell off chair

23. Signature Wilhelmina Jungwald, M. D.
Address 1673 E. Fort Ave. Date signed 2/23/45

For O-C-J. Lubinski, by Howard J. Walters, M.D.

G26208

CWK 91928

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G26208
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Kilmarnoc BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 170 S MOSHER ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
John Henry Curry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife Edna Curry ??

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14-1920

8. AGE: Years 24 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John F. Conquest, (Stepfather)
13. Birthplace Virginia

MOTHER
14. Maiden Name Emma Curry
15. Birthplace Virginia

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 2-24-45
(month) (day) (year)
(c) Cemetery or crematory Kilmarnock.
Location Va.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Brentman St.

19 (a) (Date rec'd by registrar) (b) Huntington Millard, M.D. Registrar

FEB 24 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22 1945, at 7 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3 1945, to 2-22 1945, and that I last saw h[illegible] alive on 2-22 1945.

Immediate cause of death Pulmonary tuberculosis — Duration 8 mo ?

Due to

Due to

Other Conditions Tuberculoma of hemisphere of L. ? TBC peritonitis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Curry M. D.
Address City Hosp. Date signed 2-24-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 626209

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1618 Shakespeare St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Shakespeare St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Bryostek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Casper Bryostek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business Home

FATHER
12. Name Antoni Magralski
13. Birthplace Poland

MOTHER
14. Maiden Name Straczynska
15. Birthplace Poland

16 (a) Informant Casper Bryostek
(b) Address 1618 Shakespeare St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Brazenski
(b) Address 1930 Eastern Ave.

19 (a) FEB 24 1945 (Date filed by Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 1945 at 8:15 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio-vascular disease
Hypertension

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 2-23-45

26210 X G26210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1624 Normal Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Patient
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Hampden (Rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Jarrettsville Pike
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Christina C. Rider (Reuter)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Jacob Rider
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1861

8. AGE: Years 83 | Months 6 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John Witter
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Mrs. John A Rider
(b) Address: Hampden, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26 1945 (month) (day) (year)
(c) Cemetery or crematory: St. Johns
Location: Sweet Air, Balto. Co., Md.

18 (a) Funeral director: London M. Beverly
(b) Address: Sparks, Md.

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by Registrar) FEB 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24 1945, at 3:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/8 1945 to 2/24 1945; and that I last saw her alive on 2/23 1945.

Immediate cause of death: Hypertension arteriosclerotic cardiovascular renal disease — Duration: ?

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Helen D. Mayonnia, M.D.
Address 1645 N. Gay St. Date signed 2/24/45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6206211 V108 Registered No. 1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution:
Univ Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write "Rural" and give town)
(d) Street No. 3522 ~~Harford~~ Hoffman Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Hepplding

3 (b) If veteran, name war —

(c) Social Security Account No. 215-57-2393

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Louise Hepplding

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1st 1891

8. AGE: Years 53 | Months 7 | Days 21 | If less than one day: hr. min.

9. Birthplace new Jersey (Town, county, and state)

10. Usual Occupation Welder Shipworker

11. Industry or business

FATHER 12. Name Fredrick Hepplding

13. Birthplace Germany

MOTHER 14. Maiden Name Louise E Ling

15. Birthplace Germany

16 (a) Informant Family

(b) Address 3522 Hoffman Ave. 2/1/45

17 (a) B. (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Glen Haven

Location Glen Burnie

18 (a) Funeral director Jos F McCauley

(b) Address 402 E Fort Ave.

19 (a) (Date per day register) (b) Registrar Huntington Williams M.D.

FEB 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22 1945 at 10 30/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20 1945 to 2-22 1945 and that I last saw him alive on 2-22 1945.

Immediate cause of death	Duration
Cardiac Failure	
Due to Lobar Pneum Type XII	
Due to Septicemia Pneumo XII Meningitis Pneumo XII	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. Funkhouser M. D.

Address Univ Hosp Date signed 2-22-45

X

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G26212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G26212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: FRANKLIN SQUARE HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County.....
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 722 W. WEST ST. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME HARRY A. GASSAWAY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife ANNIE E GASSAWAY
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) NOV 1 1867

8. AGE: Years 77 | Months 3 | Days 21 | If less than one day .....hr. .....min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER
12. Name EDWARD GASSAWAY
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ALICE TAYLOR
15. Birthplace MARYLAND

16 (a) Informant ANNIE E GASSAWAY
(b) Address 722 W. WEST ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-26-45 (month) (day) (year)
(c) Cemetery or crematory MT. OLIVET CEM
Location BALTIMORE MD

18 (a) Funeral director Bernard G. Hasle
(b) Address 121 E WEST ST

19 (a) (Date received by Registrar) FEB 24 1945 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 22 1945, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945, to Feb 22 1945, and that I last saw him alive on Feb 22 1945.

	Duration
Immediate cause of death Pneumonitis & bronchitis	2 days
Due to Malignancy of bone	??
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....(Specify type of place)
(e) Means of injury.....

23. Signature [illegible]
Address 1701 Cumberland Ave Date signed 2/22/45

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

626213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

626213 / 13a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 421 FOLSOM ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 FOLSOM. ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THERESA. B. THUMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEM | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife GEORGE H. THUMA

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JUNE 16-1876

8. AGE: Years 68 | Months 8 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation HOUSE WORK

11. Industry or business AT HOME

FATHER
12. Name ANDREW FRITZ
13. Birthplace BALTIMORE MD

MOTHER
14. Maiden Name ANNA WAGNER
15. Birthplace BALTIMORE MD

16 (a) Informant MRS JOHN FORTMAN

(b) Address 442 E FORT AVE

17 (a) BURIAL (b) Date thereof 2-26-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory HOLY CROSS CEM

Location A. A Co.

18 (a) Funeral director Bernard C Hanke

(b) Address 121 E West ST

19 (a) 1945 (Date rec'd by registrar) Baltimore MD

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 23 1945 at 12 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1945 to Feb 23 19 45 and that I last saw h alive on Feb 22 19 45

Immediate cause of death	Duration
Arteriosclerosis	
Arterial Hypertension	
Due to Chr Nephritis	
Terminal Regurgitation Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr S H Romano M. D.

Address 436 E Fort Ave Date signed 2/23/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

626214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. 626214

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 N. Denham Rt
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30-1943

8. AGE: Years 1 Months 16 Days 22 If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Leo. Wright
13. Birthplace Penna

MOTHER
14. Maiden Name Mahrojine a Marshall
15. Birthplace Baltimore Md

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2 26 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North ave

18 (a) Funeral director Clarence E. Wellmore
(b) Address 1539 Aisquith

19 (a) FEB 24 1945 (b) Hunting Town, Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

~~Immediate cause of death~~ Clinical diagnosis: Upper respiratory infection — Duration 2-3 days

Due to cong amputation of arms

Due to

Other Conditions treated subdural hematoma old.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: report to follow

of autopsy: not yet reported.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John R. Brimingham M. D.
Address 000 Date signed 2-23

For C. J. Lubinski, by Thomas J. Mullen, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G26215

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 E. Oliver St.
(c) Hospital or institution:
8-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 E. Oliver St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FANNIE BENESCH

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~or wife~~: Charles Benesch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Ab't 1857.

8. AGE: Years: About 88 | Months | Days | If less than one day: hr. min.

9. Birthplace: Austria. (Town, county, and state)
10. Usual Occupation: None
11. Industry or business

FATHER
12. Name: Eli Benesch,
13. Birthplace: Austria.

MOTHER
14. Maiden Name: Sarah Benesch,
15. Birthplace: Austria.

16 (a) Informant: Mr. Isidore Benesch,
(b) Address: 6201 Harford Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2.25.45. (month) (day) (year)
(c) Cemetery ~~or crematory~~: Hebrew Friendship
Location: Balto. Md.

18 (a) Funeral director: Harris Sonnenstein & Son
(b) Address: 1902 Eutaw Place.

19 (a) (b) Huntington Williams, M.D. Registrar

FEB 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22nd. 1945, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/81 1938 to 2/22/ 1945.
and that I last saw h~~er~~ alive on Feb 22 1945.

Immediate cause of death: Senility & Arteriosclerosis
Chronic Myocarditis — Duration: 20 yrs 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M B Levin M. D.
Address 211 W. Monument St. Date signed Feb 23/45

X

G26216
AB-92108

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

G26216
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2018 McCulloh Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Blake

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20- 1881

8. AGE: Years 63 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Vincent Blake (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Mary ? (D)
15. Birthplace Md.

16 (a) Informant Records (Baltimore City Hospitals)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 27/45 (month) (day) (year)
(c) Cemetery or crematory Adams
Location Lothian, Md. A. & Co

18 (a) Funeral director J. B. Ingram
(b) Address Annapolis

19 (a) (Date rec'd by registrar) FEB 24 1945 (b) Huntingtor Maryland

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22- 19 45 at 10.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12- 19 45 to 2-22 19 45 and that I last saw h. 1m alive on 2-22- 19 45

Immediate cause of death Uremia — Duration 7

Due to Nephro-sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. A. Harry, J. M. D.
Address City Hosp. Date signed 2-24-45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V108

626217

Registered No. .....

Please write plainly, with ink or indelible pencil, and do not use abbreviations. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 636 N. Carrollton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 636 N. Carrollton Ave.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Graham

3 (b) If veteran, name war

3 (c) Social Security Account No. 226-09-6631

4. Sex male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ethel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 02-29-1898

8. AGE: Years 46 | Months 11 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Hilzo, N.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Ethel Graham
(b) Address 112 Division St.

17 (a) Burial (b) Date thereof Feb. 24, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cem.
Location Suffolk, Va.

18 (a) Funeral director Wm. Jas. H. Hulbert
(b) Address 1631 Druid Hill Ave.

19 (a) (b) Huntington, W. Virginia

FEB 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22 1945, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20 1945 to 2/22 1945.
and that I last saw him alive on 2/22 1945.

Immediate cause of death	Duration
Left Lobar Pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Welcome M. D.
Address 1631 Harlem Date signed 2/24/45

X

G26213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

460

G26213 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 606 N. Ellwood Ave.
(c) Hospital or institution:

7-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 N. Ellwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENA A. EACKLES

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles T. Eackles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 21, 1876

8. AGE: Years	Months	Days	If less than one day
68	9	1	hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Adam Wiegand
13. Birthplace: Germany

MOTHER
14. Maiden Name: Eva Meister
15. Birthplace: Germany

16 (a) Informant: Mr. Charles W. Eackles
(b) Address: 718 Lyndhurst St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/45 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) FEB 24 1945 (Date rec'd by registrar) Huntington W. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22, 1945, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943 to Feb 22 1945, and that I last saw her alive on Feb 21 1945.

Immediate cause of death	Duration
Carcinomatosis —	Oct-1943
Due to Carcinoma of Rectum —	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation Nov 1943
Major findings of operation: carcinoma of Rectum
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Louis F. Krumsiek M.D.
Address 722 N. Kenwood Ave Date signed 2/27/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

620219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 620219

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1831 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1831 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: JOSEPH O. TROUTMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife: Mary B. Troutman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/26/1869

8. AGE: Years	Months	Days	If less than one day
75	9	26	hr. min.

9. Birthplace Bedford Co., Pa. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James W. Troutman
13. Birthplace Pa.

MOTHER
14. Maiden Name Huldah Willison
15. Birthplace Pa.

16 (a) Informant Mr. Howard A. Troutman
(b) Address 3434 Mondawmin Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/25/45 (month) (day) (year)
(c) Cemetery or crematory
Location Clearville, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 24 1945 (Date received by registrar) Huntingdon Pennsylvania

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22, 1945, at 5:00PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 1945, to 2/22 1945, and that I last saw him alive on 2/21 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Congestive heart failure	
Due to Coronary artery disease	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. Howard Troutman
Address 601 N. Broadway Date signed 2/23/45

VS 150

AF 90720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D Registered No. G60220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos-5days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 741 E. Fort Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Zell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife William (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3- 1872

8. AGE: Years	Months	Days	If less than one day
72	9 7	19	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Chaney (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Serah Jones
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Road

18 (a) Funeral director Leo G. Cook
(b) Address 1701-05 N. Patterson Park Ave

19 (a) (Date rec'd by registrar) FEB 24 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22- 1945 at 11.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-17 1944 to 2-22 1945, and that I last saw her alive on 2-22- 1945

Immediate cause of death	Duration
Coronary thrombosis	12 days
Cardiac insufficiency	12 days
Due to Arteriosclerotic Hypertensive heart disease	
Due to	
Other Conditions Amputation right leg (Include pregnancy within 3 months of death)	?

Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospitals Date signed 2-23-45

VS 150

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

62621

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937 Registered No. 62621

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Genl Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 Chesapeake Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Malcolm May

3 (b) If veteran, name war

3 (c) Social Security Account No. 406-09-7783

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Stone Kentucky (Town, county, and state)
10. Usual Occupation Ship Fitter
11. Industry or business Bethlehem Fairfield

FATHER
12. Name Moses B. May
13. Birthplace Stone Ky

MOTHER
14. Maiden Name Elizabeth Hunt
15. Birthplace Stone Ky

16 (a) Informant Mrs May
(b) Address Leonada Ky.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26th 1945 (month) (day) (year)
(c) Cemetery or crematory
Location Williamson W. Va.

18 (a) Funeral director Leo S. Crook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) FEB 24 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1945, at 3 40 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to Pulmonary Emphysema

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner)
Date signed Feb 21 1945

VS 151

626222

HEALTH DEPARTMENT—CITY OF BALTIMORE

626222

CERTIFICATE OF DEATH 108

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 N Schroeder St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Harvey Davis

If U. S. Veteran specify WAR

(a) Residence: No. 206 N Schroeder St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Davis

6. DATE OF BIRTH (month, day, year) Jan. 1910.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
35	1	21	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) present

11. Total time (years) spent in this occupation Lifetime

12. BIRTHPLACE (city or town) (State or country) MD. Cameron

FATHER

13. NAME Harvey Davis

14. BIRTHPLACE (city or town) (State or country) Cameron MD

MOTHER

15. MAIDEN NAME Susanna Smith

16. BIRTHPLACE (city or town) (State or country) Cameron MD

17. INFORMANT Mrs. Sarah Davis
(Address) 206 N. Schroeder St

18. BURIAL, CREMATION, OR REMOVAL
Place Mt. Auburn Date Feb. 24 1945

19. UNDERTAKER Mrs. Katie R. Williams
(Address) 322 N. Schroeder St.

20. FILED FEB 24 1945 Katie Williams, M.D. Registrar.

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 2-21 1945

22. I HEREBY CERTIFY, That I attended deceased from Feb 18, 1945 to Feb 21, 1945

I last saw h alive on Feb 20, 1945 Death is said to have occurred on the date stated above, at 7:24 a.m.

The principal cause of death and related causes of importance were as follows:

a. Coronary Thrombosis — Date of onset

Other contributory causes of importance:

Emphysema and Congestive Cardiac Failure

Was an operation performed? No Date of —

For what disease or injury? —

Name of operation —

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? No Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

No If so, specify

(Signed) Thos S Bankson M. D.

(Address) 1202 Druid Hill Ave

VS 3

626223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 626223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 N. Gilmor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1941
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 501 N. Gilmor St (If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel Gordon

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Col.	Widowed

6 (b) Name of husband ~~or wife~~ James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-8-1912

8. AGE: Years	Months	Days	If less than one day
32	8	13	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Isaiah Uzzle
13. Birthplace Va.

MOTHER
14. Maiden Name Otella Uzzle
15. Birthplace Va.

16 (a) Informant Mary Marshall (a)
(b) Address 531 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-45 (month) (day) (year)
(c) Cemetery or crematory Smithfield Cem.
Location Smithfield Va.

18 (a) Funeral director Chas. H. Foster
(b) Address 572 N. Calhoun St.

19 (a) FEB 24 1945 (Date rec'd by registrar) (b) Huntington Ave. Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22 1945, at 2:29 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/19 1945 to 2/22 1945, and that I last saw her alive on 2/21 1945.

Immediate cause of death	Duration
Rt Lobar Pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hall Boone M. D.
Address 1173 Hanlon Dr. Date signed 2/23/45

G66224 ✓ G66224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: President Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md. 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Roland Grass

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife Marie Bluer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1907

8. AGE: Years	Months	Days	If less than one day
37	7	24	hr. min.

9. Birthplace A. A. Co., Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Robert Gross
13. Birthplace Calvary Co., Md.

MOTHER
14. Maiden Name Rosetta Sparrow
15. Birthplace A. A. Co., Md.

16 (a) Informant Mrs Sophia Burley
(b) Address 222 N. Carey

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 25 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) FEB 24 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1945, at 12 50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9 1945, to 2/22 1945, and that I last saw him alive on 2/22 1945.

Immediate cause of death Aortic Aneurysm

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Aneurysm of Aorta

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature J. R. Coarey M. D.
Address Provident Hospital Date signed 2/22/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

626225
468489

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

15

626225
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	married

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) 11-12-12.

8. AGE: Years	Months	Days	If less than one day
32	3	11	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Charles R. Robinson
13. Birthplace S. C.

MOTHER 14. Maiden Name Mollie Quattlebaum
15. Birthplace S. C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Feb. 25 '40 (month) (day) (year)
(c) Cemetery or crematory Batesburg, S. C.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) FEB 24 1945 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23. 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1945, to Feb. 23 1945, and that I last saw him alive on Feb. 23 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Disseminated Tuberculosis	
Due to Tuberculous peritonitis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Dixon
Johns Hopkins Hosp. Date signed 2/29/40

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Every item of correct age is especially important.

VS 150

G26226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G26226 26226

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4211 Oakford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4211 Oakford Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary E. Eyland

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Late Andrew V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14th 1869

8. AGE: Years 75 | Months 4 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Cumberland, Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business At home

FATHER
12. Name Henry B Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Sanders
15. Birthplace Cumberland, Md.

16 (a) Informant Mr. J. Eyland
(b) Address 4211 Oakford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/45 (month) (day) (year)
(c) Cemetery or crematory St Peter & Paul Cem
Location Cumberland, Md

18 (a) Funeral director John J Conway & Son
(b) Address 22-28 Hollins St

19 (a) FEB 25 1945 (Date rec'd by registrar) Registrar

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22nd 1945, at 9P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Feb 22 1945 and that I last saw h[illegible] alive on Feb 21 1945.

	Duration
Immediate cause of death Coronary Thrombosis	3 hrs.
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. [illegible] M. D.
Address 1156 Poplar Grove St Date signed 2/23/45

G20622 ✓ G20622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 Buren St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 Dillon St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Nagle

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: none
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 19th 1912

8. AGE: Years 32 | Months 8 | Days 4 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business —

FATHER
12. Name Sylmwood Johnson
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Bertha Johnson
15. Birthplace Balto. Md.

16 (a) Informant Geo. Johnson
(b) Address 3211 Dillon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location 3801 Frederick Ave

18 (a) Funeral director John F. Cowan & Co
(b) Address 1403 E. Baltimore St.

19 (a) [illegible] registrar (b) Huntington Williams, M.D.

B 2 1949
VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 19 45 at 8:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9 19 45 to 2/23 19 45 and that I last saw h. alive on 2/23 19 45

Immediate cause of death: Cardiac failure (decompensation)

	Duration
Due to	
Due to	
Other Conditions: Mitral regurgitation	Unknown

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Mac Murchy M. D.
Address 801 Buren St Date signed 2/23/45

X

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G26228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G26228
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fulton and Madison
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2262 Cedley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter E. Widerman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Frances E. Widerman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 21, 1865

8. AGE: Years	Months	Days	If less than one day
79	4	2	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Widerman
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth A. Longley
15. Birthplace Maryland

16 (a) Informant Mr. W. W. Widerman
(b) Address 615 Coleraine Rd., Catonsville

17 (a) Burial (b) Date thereof Feb. 26, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Willis Lawrence
(b) Address 1805 W. Baltimore St.

(a) FEB 23 1945 (by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23/45 19 . at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1945 to 2-23 1945, and that I last saw him alive on 2-23 1945.

Immediate cause of death	Duration
Peripheral circulatory collapse	
Due to Deliritation and T.b.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature
Address Md. Genl Hosp. Date signed 2/23/45
M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G26623 BALTIMORE CITY HEALTH DEPARTMENT G26623
CERTIFICATE OF DEATH 61 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2917 Norfolk Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2917 Norfolk Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris A. Dobres
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-03-3426

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Anna M
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1895
8. AGE: Years 50 Months Days If less than one day hr. min.
9. Birthplace N. Y. (Town, county, and state)
10. Usual Occupation
11. Industry or business Printing Business

FATHER
12. Name Abraham Dobres
13. Birthplace Russia

MOTHER
14. Maiden Name Balle ?
15. Birthplace Russia

16 (a) Informant Anna Dobres
(b) Address 2917 Norfolk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 25, 1945 (month) (day) (year)
(c) Cemetery or crematory Sharrei Zion Cemetery
Location Rosedale Hamiltom Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 FEB 25 1945 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22-1945, at 10 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20-1945 to 2-22-1945 and that I last saw h in alive on 2-22-1945.

	Duration
Immediate cause of death Acute pulm. edema	1 hr
Due to Myocardial infarction	4½ wks.
Due to	
Other Conditions Diabetes mellitus	6 mos

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1116 E. Eden St Date signed 2-23-45

VS 150

94a

G26230 BALTIMORE CITY HEALTH DEPARTMENT G26230

CERTIFICATE OF DEATH 195E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Winchester
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 W. Clifford St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frederick R. Mills

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace Winchester Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Mills
13. Birthplace Frederick Co. Va

MOTHER
14. Maiden Name Katie Henry
15. Birthplace Winchester Va

16 (a) Informant

(b) Address

17 (a) Removal (b) Date thereof Feb 24, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Winchester Va.

18 (a) Funeral director Easton Bone

(b) Address Ellicott City, Md.

FEB 25 1945
(Date rec'd by registrar)

19 (a) (b) Hunting for Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24 1945, at 1.30 P.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-24 at 4/1 1.15 a M.
(b) Where did injury occur? Clearfield nr. Fombell.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?
(d) Means of injury unknown

23. Signature Howard J. Mulderig M.D.
Medical Examiner.
Date signed February 24, 1945

VS 151

G26231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

#96

G26231
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 D
(e) Length of stay in Baltimore (yrs., mos., or days) 5 D

2. USUAL RESIDENCE OF DECEASED:
(a) State N Y (b) County
(c) City or town Buffalo
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 Fay Ct
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence L. King

3 (b) If veteran, name war	3 (c) Social Security Account No.
V	V.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-27-27

8. AGE: Years	Months	Days	If less than one day
17	11	27	hr. min.

9. Birthplace N Y. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name Arthur King
13. Birthplace N.Y.

MOTHER 14. Maiden Name Libby Schriber
15. Birthplace N Y.

16 (a) Informant Recorder.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Feby. 27/45
(Burial, cremation, or removal) (Month) (day) (Year)
(c) Cemetery or crematory Forest Lawn
Location Buffalo N.Y.
18 (a) Funeral director Folsom Undertaking Rooms
(b) Address 405 Eutaw Place Balto
19 (a) (Date rec'd by registrar) (b) Easton Williams M.D. Registrar

FEB 25 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1945 at 9 56 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1945 to Feb 24 1945, and that I last saw her alive on Feb 24 1945

Immediate cause of death	Duration
Cardiac failure	
Due to Congenital heart disease	
Due to	
Other Conditions Pt. died on operating table	

(Include pregnancy within 3 months of death)

Date of operation Feb 24 1945
Major findings of operation: Ruptured aneurysm of pulmonary artery
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J C Handelman M. D.
Address JHH Date signed 2-27-45

G66232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G66232 Registered No.

Please write plainly, with unfading ink. Entry must be complete and correct as required by law. Information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4006 Southern ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4006 Southern ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna C. Schmidt

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 13, 1857

8. AGE: Years 88 | Months 1 | Days 10 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Kleinschmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Marie E. Kleinschmidt
15. Birthplace Germany

16 (a) Informant Mrs. Marie E. Klabunde
(b) Address 4006 Southern ave

17 (a) Burial (b) Date thereof 2/26/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson ave

18 (a) Funeral director Howard N. Blight Jr
(b) Address 4914 Belair Road

19 (a) Filed 2 Feb 1945 (b) Registrar M. P.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1945, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to Feb 23 1945, and that I last saw her alive on Feb 22 1945.

Immediate cause of death	Duration
Chronic Myocarditis	
Due to Arteriosclerosis	
Due to	
Other Conditions Chronic Nephritis Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 300 Shawan Road Date signed Feb. 23 45

Huntington Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26233
ABO 81208

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G26233
Registered No. 543

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr- 9 mos- 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Forrest St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Warren

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) ?-?-? 54?
8. AGE: Years 54? Months ? Days ? If less than one day hr. min.
9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ernest Johnson
13. Birthplace ?

MOTHER
14. Maiden Name Lucy ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 (month) 25 (day) 45 (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. Co. Md

18 (a) Funeral director Isaiah L Brown Son
(b) Address 1018 W Montgomery St

19 FEB 25 1945 (Date rec'd by Registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21- 1945 at 9.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-27- 1943, to 2-21- 1945, and that I last saw her alive on 2-21- 1945.

Immediate cause of death: Bronchopneumonia ?
Duration: ?
Due to
Due to
Other Conditions: Uterus carcinoma
Coronary sclerosis
(Include pregnancy within 3 months of death)
Date of operation: Endothelioma 1929
Major findings of operation: ✓
of autopsy: None Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Woodward M. D.
Address Baltimore City Hospitals Date signed 2-22-45

626254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

626254 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2530 Arunah Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2530 Arunah ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Menke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1870

8. AGE: Years 75 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Linotype Operator

11. Industry or business Sun Paper

FATHER 12. Name Frederick W. Menke

13. Birthplace Md.

MOTHER 14. Maiden Name Mary Topp

15. Birthplace Germany

16 (a) Informant Mrs. Koenig

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3801 Frederick Ave

18 (a) Funeral director Harry H. Little

(b) Address 410 E. Edmondson ave

B 2 5 1945 (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22. 1945, at M

21. I certify that death occurred on the date above stated, that I attended deceased from Feb-19 1945, to Feb-22 1945, and that I last saw h alive on 19

Immediate cause of death Carcinoma - Rectum.

Duration 1/2-1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation No

Major findings of operation: —

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide? No

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature B. Lloyd Johnson M. D.

Address Catonsville Md Date signed 2-24-45

VS 150

X

G26235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G26235 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 W. Mulberry ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Harley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 23, 1912

8. AGE: Years	Months	Days	If less than one day
33	11	29	hr. min.

9. Birthplace Florence S.C.
(Town, county, and state)

10. Usual Occupation Barber.

11. Industry or business

FATHER
12. Name Rev. Sidney Harley
13. Birthplace Florence S.C.

MOTHER
14. Maiden Name Eugenia Timmons
15. Birthplace Florence S.C.

16 (a) Informant Mrs Eugenie Hall
(b) Address 1125 St James St Richmond Va

17 (a) Burial (b) Date thereof Feb 25 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Richmond, Va
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St.

19 (a) FEB 25 1945 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1945, at 6 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Pulmonary Tuberculosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb. 22 1945

VS 151

X

G26236
AB-92132

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G26236
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Brady Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Camphor

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Fannie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 16, 187[illegible]
8. AGE: Years 71 | Months 2 | Days 5 | If less than one day ..... hr. ..... min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name John Camphor
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Jones
15. Birthplace Md.

16 (a) Informant Balto. City Hosp. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Balto. Co. Md.

18 (a) Funeral director Chas. L. Cobb
(b) Address 5128 Carrollton Ave.

19 (a) [illegible] (b) Huntington Williams, Registrar
(Date rec'd by registrar) FEB 25 1945

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1945, at 2:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14 1945, to 2-21 1945, and that I last saw h im alive on 2-21 1945.

Immediate cause of death: Broncho pneumonia
Due to: Hypertensive Heart Disease
Due to:
Other Conditions: Arteriosclerotic Gangrene of foot.
(Include pregnancy within 3 months of death)
Date of operation 3-21-45
Major findings of operation:
of autopsy:

Duration: 5 day ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify t[illegible])
(e) Means of injury

23. Signature C. J. Perry M.D.
Address B.C.H. M. D. Date signed 2-21-45

G26237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G26237

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 813 Vine St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Vine St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Nettie H. Dillard

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife George

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 10-8-1892

8. AGE: Years 52 | Months 4 | Days 11 | If less than one day 12 hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel Hollis
13. Birthplace Centerville, Md.

MOTHER
14. Maiden Name Leah Green
15. Birthplace Balto. Md

16 (a) Informant Rachel Coleman (S)
(b) Address 813 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto Co. Md

18 (a) Funeral director Edwards & Sapp
(b) Address 518 N. Carrollton Av.

19 (a) (Date received by local registrar) Huntington Williams, Registrar

FEB 25, 1945

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20, 1945, at 8:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/8/1944 to 2/20/1945 and that I last saw her alive on 2/20/1945

Immediate cause of death Bronchopneumonia

Due to Terminal

Due to Carcinoma of Lung 1 yr

Due to Carcinoma of breast 1 yr

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. F. Howell M. D.

Address 601 N. Carrollton Ave Date signed 2/22/45

626638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 26230

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1622 N. Bond St.
(c) Hospital or institution:
(d) Length of stay in hospital or Inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 N. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES W. COOK

3 (b) If veteran, name war: --

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Emma Cook

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Dec. 30, 1868

8. AGE: Years 76 | Months 1 | Days 22 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Charles Cook, Sr.
13. Birthplace Dont know

MOTHER
14. Maiden Name Susan Baker
15. Birthplace Maryland

16 (a) Informant Katherine Jefferson
(b) Address 4502 Elsrode Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.

19 (a) Filed (b) Registrar Huntington Williams

FEB 20 19

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1945, at 11;30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2/45 19 to 2/22/45, and that I last saw h[illegible] alive on 2/22/45 19.

Immediate cause of death: Pulmonary Edema. — Duration: 12 hrs.
Due to (a) Cerebral Hemorrhage — 12 hrs.
Due to (b) Chronic Myocarditis — ?
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest Lem, M.D.
Address 1601 N. Broadway Date signed 2/23/45 M. D.

Balto-13, Md.

626233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. 626233

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Hagerstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt 5 4
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel Hartzaupt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/1944

8. AGE: Years | Months 7 | Days | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Harold Hartzaupt
13. Birthplace Md.

MOTHER
14. Maiden Name Katherine Wilson
15. Birthplace Md.

16 (a) Informant Wendo
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Feb 28-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Hagerstown

18 (a) Funeral director Fred W Kraus
(b) Address Hagerstown Md.

19 (a) (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25 1945 at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24 1945 to 2-25 1945, and that I last saw h[illegible] alive on 2-25 1945.

Immediate cause of death	Duration
Congenital Heart Disease	
Due to	
Due to	
Other Conditions Asthmatic Bronchitis	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: Malformation of Heart and of left lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harriet G. Gould M. D.
Address Johns Hopkins Hosp. Date signed 2/25/45

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VR 1M 1945

626240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. 626240

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 Linden ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Raitzyk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Louis Raitzyk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 1912

8. AGE: Years	Months	Days	If less than one day
33 ~~yr~~			hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation
11. Industry or business at home

FATHER
12. Name Saml R Stafford
13. Birthplace South Carolina

MOTHER
14. Maiden Name Elizabeth Hackett
15. Birthplace Georgia

16 (a) Informant Mrs Grady L Stafford
(b) Address Ft Howard Md

17 (a) Removal (b) Date thereof 2/25/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodruff SC
Location: Woodruff SC

18 (a) Funeral director Tillett Funeral Home
(b) Address 200 E Williams St

19 (a) FEB 26 1945 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24- 1945, at 4 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertrophic (Biliary) Cirrhosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Williams M.D.
Medical Examiner.
Date signed 2-25-45

VS 151

Dr. Januszeski
Store Bk. Harford Rd.
26241
5179

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94B

Registered No. G26241

PLEASE WRITE PLAINLY, WITH CANADIAN INK. Every item should be carefully answered. Information should be carefully and correctly given. Be sure cause of death is correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3030 Pennwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3030 Pennwood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grady Lee Zimmerman

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 1945, to 2/25 1945, last saw h.im alive on 2/25 1945.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Lena Mundy Zimmerman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10-1897

8. AGE: Years	Months	Days	If less than one day
48	—	15	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation salesman
11. Industry or business

FATHER
12. Name Alexandria Zimmerman
13. Birthplace N.C.

MOTHER
14. Maiden Name Amanda J. Senk
15. Birthplace N.C.

16 (a) Informant Mrs. Lena M. Zimmerman
(b) Address 3030 Pennwood Ave.

17 (a) Burial (burial, cremation, or removal) (b) Date thereof 2- -45 (month) (day) (year)
(c) Cemetery or crematory Trinity Lutheran
Location Winston Salem N.C.

18 (a) Funeral director Leonard J. Kuck
(b) Address 5325 Harford Rd.

19 (a) FEB 26 1945 (Date rec'd by registrar) (b) Huntington Wilson, M.D.

Immediate cause of death Angina Pectoris
Due to —
Due to —
Other Conditions Chronic Cholecystitis
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: none performed

Duration 2 mo.?

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis J. Januszeski M.D.
Address 5179 Harford Rd Date signed 2/25/45

VS 150

G26242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G26242

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland CAMEL
(b) Street address 523 Canal alley
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 W. Biddle
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Seek

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	—

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
46 45			hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mr. Williams
(b) Address 308 W. Biddle St.

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 2-27-45 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 (a) FEB 26 1945 (Date rec'd by registrar) (b) Huntington Woods, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19- 1945, at 5:50 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gunshot of neck, involving carotid artery & internal jugular vein

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-19-45 at 5:30 P. M.
(b) Where did injury occur In front of 523 Camel alley.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearm
23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 2-20-45

VS 151

626243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

130

626243 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 Oxford St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Oxford St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy Preston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895, May

8. AGE: Years	Months	Days	If less than one day
49	9		hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Maria Pendleton
15. Birthplace ?

16 (a) Informant Louise Boyer
(b) Address 620 P. Carlton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. J. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date received by Registrar) (b) Registrar

FEB 26 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22, 1945, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] to 2-22-45, and that I last saw [illegible] alive on 2-18-45

Immediate cause of death Uremic nephritis — Duration 3 days

Due to

Due to Coma — Duration 2 hrs

Other conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Lee Steele M. D.

Address [illegible] Baltimore

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26244 ✓ G26244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1601 Covington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 Covington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Kaufmann

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 219-10-6072

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Theresa M.
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Nov 19 1881

8. AGE: Years 63 | Months 3 | Days 4 | If less than one day: hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Frederick Kaufmann
13. Birthplace Balto.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Theresa M. Kaufmann
(b) Address 1601 Covington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 Balto (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Anne Arundel Co.

18 (a) Funeral director Martin F.E. Degnan
(b) Address 37 S. Ann St.

19 (a) (Date rec'd by registrar) Huntington Williams (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1945 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 1943 to 2/23 1945.
and that I last saw h[illegible] alive on 2/18 1945.

Immediate cause of death Pneumonia
Myocarditis
Due to Hypertension
Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Trumbo M. D.
Address [illegible] Date signed 2/23/45

VS 150

1 Transcript

626245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

626245

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave & John St.
(c) Hospital or institution:
Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5300 Ethelbert Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Lavenia Wareheim

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Gordon Albert Wareheim
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1912

8. AGE: Years	Months	Days	If less than one day
32	9	26	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Frank Leonard Bartgell
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Virginia May Carter
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Gordon Albert Wareheim
(b) Address 5300 Ethelbert Ave.

17 (a) Burial (b) Date thereof 2-27-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Lorenz Byers
(b) Address 1925 Park Ave.

19 (a) FEB 26 1945 (b) Hunter-Wilkams, M.K.
(Date rec'd by registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24, 1945, at 12:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from October 1, 1944 to February 24 1945, and that I last saw her alive on February 24, 1945.

Immediate cause of death	Duration
Uremia	
Due to Chonic Glomerulo-Nephritis	3 yrs.
Due to	
Other Conditions Hypertensive Cardio-Vascular Disease (Renal)	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. S. Stone III M. D.
Address Women's Hospital Date signed 2-24-45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7 Transcripts

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B Registered No. 6-45246

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution St Joseph's Hospital Balto Md
(d) Length of stay in hospital or inst. (~~yrs., mos., or days~~) 27 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5601 Park Heights Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry L. Taylor

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	M

6 (b) Name of husband or wife Mary Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 4 1887

8. AGE: Years	Months	Days	If less than one day
57	10	17	hr. min.

9. Birthplace Patapsco, Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation Operator (Street Car)

11. Industry or business Balto. Transit

FATHER
12. Name E. Erwin Taylor
13. Birthplace Patapsco Carroll Co. Md

MOTHER
14. Maiden Name Leah McGee
15. Birthplace Patapsco, Carroll Co. Md

16 (a) Informant Mrs Mary Taylor
(b) Address 560 Park Heights Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 2/26/45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Heights Ave

19 (a) FEB 26 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1945, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1945 to Feb 21 1945, and that I last saw him alive on Feb 21 1945.

Immediate cause of death	Duration
Generalized Peritonitis - Cardiac failure	
Due to Perforated duodenal ulcer, Partial obstruction, adhesions	
Due to Tbc.	
Other Conditions Pul. Tbc - Generalized C cavity formation, multiple	

(Include pregnancy within 3 months of death)

Date of operation Feb 20, 1945

Major findings of operation Generalized peritonitis, fine pus - perforated duodenal ulcer

Findings of autopsy: Tbc. Peritonitis - Perforated Duodenal ulcer - Pulmonary Tbc

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. M. Bacon Jr. M. D.
Address St. Joseph's Hospital Date signed 2-24-45

PHYSICIAN
Underline the cause to which death should be charged statistically

VS 150

G26247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G26247

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. East Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) b
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 N East Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: WILLIAM HAMPTON WRIGHT

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Separated
6 (b) Name of husband or wife: Alice Wright
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 1874
8. AGE: Years 71 | Months | Days | If less than one day hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Mgr. Cafeteria
11. Industry or business: Beth. Ship. Bldg. Co.

FATHER
12. Name: Olen Wright
13. Birthplace: Ky.

MOTHER
14. Maiden Name: Rebecca Brooks
15. Birthplace: Va.

16 (a) Informant: Mr. Walter C. Wright
(b) Address: 1647 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/1945 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

FEB 26 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23, 1945, at 7:30A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31, 1944 to Feb. 23 1945 and that I last saw h. was alive on Feby 23 1945

Immediate cause of death	Duration
Cardiac Failure.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Agnes C. Beetham M. D.
Address 3139 E. Baltimore Date signed 2-26-45

PLEASE WRITE PLAINLY, with pen and ink. Avoid use of information unless sure. Do not guess. Be careful to report correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

26248

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

112

Registered No. 26248

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2218 Aiken St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Walter Lee Mullineaux

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 717 - 07 - 7032

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine M. Mullineaux

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 30, 1897

8. AGE: Years: 47 | Months: 9 | Days: 24 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Machinist

11. Industry or business: Penna. R. R.

FATHER
12. Name: Walter P. Mullineaux
13. Birthplace: A. A. Co., Md.

MOTHER
14. Maiden Name: Sarah A. Parson
15. Birthplace: Balto. Co., Md.

16 (a) Informant: Mrs. Katherine M. Mullineaux
(b) Address: 2218 Aiken St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/45 (month) (day) (year)
(c) Cemetery or crematory: Moreland Mem. Pk. Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) FEB 26 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24/45 19 , at 5.0 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13/45 19 to 2/24/45 19 , and that I last saw h/ alive on 2/23/45 19 .

	Duration
Immediate cause of death: Congestive heart failure	2 days
Due to: Status Asthmaticus	17 days
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Thayer S. Waldrop M. D.
Address: Bon Secours Hosp. Date signed: 2/25/45

VS 150

G 26249 35-665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 a

Registered No. 266249

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City of Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2821 Hemlock St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry (Edward) Hohenberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Margaret E.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July-14-1870

8. AGE: Years	Months	Days	If less than one day
74	7	11	....hr. ....min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Hohenberger
13. Birthplace Germany

MOTHER
14. Maiden Name Barbera Meisel
15. Birthplace Germany

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-45 (month) (day) (year)
(c) Cemetery or crematory Dealin
Location Baltimore

18 (a) Funeral director Jos. Jacobs & Son
(b) Address 1925 Pennsylvania

19 (a) FEB 26 1945 (Date rec'd by registrar) (b) Huntington Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb-25-1945 at ....M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24-1945 to 2-25-1945, and that I last saw h[illegible] live on 2-25-1945

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Coronary occlusion? Embolism to mesenteric artery?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Hagelthorn M. D.
Address JHH Date signed 2-25-45

VS 130

626230 ✓ 626230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2621-E. Preston St.
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2621 E Preston St
(If rural give location)
(e) If foreign born, how long in U. S. A.? Life years

3 (a) FULL NAME Frances Edgar Chaplain

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Jas. F. Chaplain
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 27 1856

8. AGE: Years 88 | Months 10 | Days 29 | If less than one day: hr. min.

9. Birthplace Easton - Talbot Co.
(Town, county, and state)

10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Thomas H. Edgar
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Mason
15. Birthplace Maryland

16 (a) Informant Mrs Sarah Lytton (sister)
(b) Address 1404 W. Lafayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-45 (month) (day) (year)
(c) Cemetery or crematory Spring Hill
Location Easton - Md.

18 (a) Funeral director Stewart Mortuary
(b) Address 108 W North Ave.
Mortuary for Williams, Md

19 (a) FEB 26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1945, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1945 to Feb 25 1945 and that I last saw him alive on Feb 24 1945.

Immediate cause of death Chr. myocarditis

Due to arteriosclerosis

Due to .....

Other Conditions senility
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Walter A Anderson M. D.
Address 3001 Sherwood Drive Date signed 2-25-45

VS 3

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

626251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940

Registered No. 626251

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave. & Lake Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Riviera Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY SLOMAN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of ~~husband or~~ wife Bettie Sloman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 14, 1863

8. AGE: Years	Months	Days	If less than one day
81	11	10	hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business

FATHER
12. Name Solomon Sloman,
13. Birthplace Germany.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Germany.

16 (a) Informant Mr. Herbert Sloman,
(b) Address Riviera Apts.

17 (a) Burial (b) Date thereof 2.26.45.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Oheb Shalom
Location Balto. Md.

18 (a) Funeral dir. Harris Sonnenstein & Son
(b) Address 1902 Eutaw Place.

19 FEB 26 1945 Huntington Williams M.D.
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24th. 1945, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1944, to Feb 24 1945, and that I last saw h(im) alive on Feb 24 19 45

Immediate cause of death	Duration
Coronary Sclerosis	2 yrs
Due to Arterio Sclerosis	10 yrs
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Emma E. Leagers
Address Esplanade Apts. Date signed 2/25/45

620652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. 620652

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 651 Dumbarton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 651 Dumbarton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William J. Green

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of ~~husband~~ or wife: Nellie E. Green
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 21st 1863

8. AGE: Years 81 | Months 2 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Robert Green
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth McGoffin
15. Birthplace Scotland

16 (a) Informant W. Russell Green
(b) Address 6309 Mossway

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 2/27/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 – 1945, at 7:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1943 to Feb. 23, 1945. and that I last saw him alive on Feb. 23, 1945.

Immediate cause of death: Myocardial degeneration — Duration 2 yrs.

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Willis Guyton M. D.
Address 3983 Greenmount Ave. Date signed 2/24/45.

Burtington Williams, M.D.

G60253 — BALTIMORE CITY HEALTH DEPARTMENT — 93D — G60253 Registered No.

CERTIFICATE OF DEATH

Please write the causes of death clearly and legibly. Physicians: please write the cause in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1915 Hope St.
(c) Hospital or institution:
9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Hope St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Dressel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
F	W	Widowed

6 (b) Name of husband or wife Conrad J. Dressel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31st 1869

8. AGE: Years	Months	Days	If less than one day
75	6	22	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name (Not Known) Schreffler
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Madeline Stinebaugh
(b) Address 1915 Hope St

17 (a) Burial (b) Date thereof 2/27/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 26 1945
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23- 1945, at 12 M

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 2-24-45

626254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

350 Registered No. 626254

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Ave
(c) Hospital or institution: Home for the Aged of the Methodist Church
(d) Length of stay in hospital of inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Myers

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 1st 1868

8. AGE: Years	Months	Days	If less than one day
77	1	24	hr. min.

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation Inmate
11. Industry or business Home for Aged

FATHER
12. Name Wallace Myers
13. Birthplace N. Y.

MOTHER
14. Maiden Name Clementine Collins
15. Birthplace Va

16 (a) Informant Record Home for Aged
(b) Address 2211 Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 27 1945 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24th 1945, at 2.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1945, to Feb 23, 1945, and that I last saw h[illegible] alive on Feb 23 1945.

Immediate cause of death	Duration
Bronchopneumonia	5 days
Due to Senility	15 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Arthur J. Bonier. M. D.
Address 900 N Broadway Date signed 2-26-45

X

626655

TO #92259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

626655 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Carson

3 (b) If veteran, name war: n

3 (c) Social Security Account No. 212-07-1294

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of ~~husband or~~ wife Katherine Carson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14 1884

8. AGE: Years 60 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Pimlico Jockey Club

FATHER
12. Name William M. Carson (d) ?
13. Birthplace Md. (Balto)

MOTHER
14. Maiden Name Mary E. Martin
15. Birthplace Md. (Balto.)

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

19 (a) FEB 26 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24, 1945, at 7:00AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22, 1945, to Feb. 24, 1945, and that I last saw him alive on Feb. 23, 1945.

	Duration
Immediate cause of death: Cerebral accident (probably thrombosis)	2 da.
Due to	
Due to	
Other Conditions: diabetes mellitus; hypertension cardiovascular disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. E. Purdy M. D.
Address City Hosp. Date signed 2-24-45

93D

VS 150

Please write plainly, with ink or indelible pencil. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 166 G66256

G66256

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 N. Schroeder St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathaniel Lewis

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 117-07-4367

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-24-1913

8. AGE: Years	Months	Days	If less than one day
32	—	—	hr. min.

9. Birthplace Rocky Pt. N.C.
(Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER
12. Name Nathaniel Russ
13. Birthplace N.C.

MOTHER
14. Maiden Name Maggie Lewis
15. Birthplace N.C.

16 (a) Informant Maggie Copeland (mother)
(b) Address [illegible] Rocky Pt. N.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/45 (month) (day) (year)
(c) Cemetery or crematory Mulberry Branch
Location Long Creek, N.C.

18 (a) Funeral director Chas. H. Cooke
(b) Address 512 N. Campbell Ave

19 FEB 26 1945 (b) Huntington, W. Va.
FEB 26 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24, 1945, at 5 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Gunshot wound of back and legs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 508 N. 2/23/45
(b) Where did injury occur? S.E. Cor. Myrtle Ave. & Mulberry streets
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Shot

23. Signature Robert Lee Fraternal M.D.
Medical Examiner.
Date signed Feb 24 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G26257

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Green sts

(c) Hospital or institution: University Hospital 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 614 Bitcher St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mary C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1877

8. AGE: Years 67 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Calvert Co. Md. (Town, county, and state)

10. Usual Occupation Post Office

11. Industry or business

FATHER

12. Name John Jenkins

13. Birthplace Md.

MOTHER

14. Maiden Name Mary King

15. Birthplace Md.

16 (a) Informant Mary C. Jenkins

(b) Address 614 Bitcher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26, 1945 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.

Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lew. V. Stallard

(b) Address 103 Edmondson Ave.

19 (a) (b) Huntington Williams

FEB 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24 1945, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1945, to 2/24 1945, and that I last saw h[illegible] alive on 2/24 1945.

Immediate cause of death	Duration
Heart Failure	2 hours
Due to Arteriosclerotic heart disease	10 yrs
Due to Diabetes Mellitus	4 yrs Known
Other Conditions Diabetic Mellitus - Gangrene - Rt. & Lt. legs	

(Include pregnancy within 3 months of death)

Date of operation 2/21/45

Major findings of operation: Diabetic gangrene - osteomyelitis Rt & Lt legs.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature P. F. Futterman M. D.

Address University Hospital Date signed 2/27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be complete and correct as to the causes of death clearly and legibly. Ages must be stated in every case where the exact age is especially important. Physicians: please write the cause of death in plain terms.

626258 ✓ 626258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Cecelia Talbot

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years 85 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housemaid

11. Industry or business

FATHER
12. Name Wesley Tolbert
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Prescot
15. Birthplace Md.

16 (a) Informant Miss Rosa Stewart
(b) Address 822 N. Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-45 (month) (day) (year)
(c) Cemetery or crematory
Location Putty Hill, Balto. Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.
FEB 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24, 1945, at 7 55 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17 1945 to 2/24 1945, and that I last saw her alive on 2/24 1945

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to	
Due to	
Other Conditions Diabetes Mellitus, Lobar Pneumonia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. D. Carr
Address Provident Hospital Date signed 2/27/45

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

626259 ✓ 626259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 402 Gold Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 Gold Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELEANOR E. HENSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife George Henson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day. yr.) July 23, 1874

8. AGE:	Years	Months	Days	If less than one day
	70	7	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel Russell
13. Birthplace Md.

MOTHER
14. Maiden Name Viola Murdoch
15. Birthplace Md.

16 (a) Informant Mr. George Henson
(b) Address 504 Gold Street.

17 (a) Burial (b) Date thereof 2-28-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578. W. Biddle St.

19 (a) (b)
(Date rec'd by Registrar) Registrar

FEB 26 1945 Washington Maryland MD

VS 180

MEDICAL CERTIFICATION A

20. DATE OF DEATH Feb. 24, '45 19 , at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1945, to Feb 24 1945, and that I last saw h[illegible] alive on Feb 23 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 2 mos
Due to
Due to
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jno. Pettitane M. D.
Address 217 N Carrollton Ave Date signed Feb 26 1945

X

G66260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G66260

Please answer all questions in full. Spell out all words. Use ink. Do not abbreviate. If the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 322 S. Mount ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Bollack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1883

8. AGE: Years	Months	Days	If less than one day
61	5		hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Balto. City

FATHER
12. Name Geo. Bollack
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Johanna Buth
15. Birthplace Germany

16 (a) Informant Louis C. Schaefer
(b) Address 1000 Rosedale St.

17 (a) Burial (b) Date thereof Feb. 26, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) FEB 26 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1945, at 11 30 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Bratton M.D.
Medical Examiner.
Date signed Feb 24 1945

VS 151

G26261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G26261 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1433 Bank Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1433 Bank Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Link (LINKIEWICZ)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2-1897

8. AGE: Years 47 | Months 9 | Days 22 | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Leader

11. Industry or business Fairfield Ship Yard

FATHER 12. Name Frank Linkiewicz
13. Birthplace Poland

MOTHER 14. Maiden Name Paulina
15. Birthplace Poland

16 (a) Informant Helen Link
(b) Address 1433 Bank St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-45 (month) (day) (year)
(c) Cemetery or crematory Russian-orthodox
Location A. A. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

FEB 26 1945 Hunting for Witness Mgt
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24, 1945 at 3 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Lia death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Cardiac Failure

Due to

Other Conditions Acute Congestion + edema of Lungs
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 2-24-45

VS 151

G26262 ✓ G26262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 30 E. Hill St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 30 E. Hill St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Anthony Cucina

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Jennie Cucina
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 3rd 1869

8. AGE: Years	Months	Days	If less than one day
75	5	21	..... hr. ..... min.

9. Birthplace Palermo Italy
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Salvatore Cucina
13. Birthplace Italy

MOTHER
14. Maiden Name Rosina Rizzo
15. Birthplace Italy

16 (a) Informant Jennie Cucina (Wife)
(b) Address 30 E. Hill St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 27/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) ..... (b) ..... Registrar

FEB 26 1945 Livingston Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24/45 1945 at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 19 44 to Feb 24 19 45 and that I last saw h. me alive on Feb 24 19 45.

Immediate cause of death	Duration
Coronary Heart Disease	3 day
Due to	.....
Due to	.....
Other Conditions Senility Enterocolitis (Include pregnancy within 3 months of death)	.....

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature J. Miller M.D.
Address 225 S. Charles St. Date signed 2/26/45

X

626263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

626263 Registered No. 157 E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3717 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl DeFazio

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W | 6 (a) Single, ~~married, widowed~~, or ~~divorced~~.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24 1945

8. AGE: Years | Months | Days | If less than one day 4 hr. 5 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John D. De Fazio
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Rita Di Giacomo
15. Birthplace Baltimore Md.

16 (a) Informant John De Fazio (Father)
(b) Address 2717 E. Pratt St.

17 (a) Burial (b) Date thereof Feb. 26/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Rd. Balt. Md.

18 (a) Funeral director Frank D. Della Rose
(b) Address 52 N. Morley St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar
FEB 26 1945

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1945, at 1 35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1945 to Feb 25 1945, and that I last saw her alive on Feb 25 1945.

Immediate cause of death	Duration
CARDIAC FAILURE	
Due to CONGENITAL INTRAVENTRICULAR SEPTAL DEFECT	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: CONGENITAL HEART DISEASE

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard W. Lindsay M. D.
Address St. Joseph's Hosp. Date signed 2-25-45

PHYSICIAN
Underline the cause to which death should be charged statistically.

G66264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931 ✓

G66264 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave. & Madison St.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore # 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 Maryland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Addie K. Peel

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: John R. Peel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/9/1878 1868

8. AGE: Years 76 | Months 10 | Days 16 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George W. Bowersox
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah C. Kendig
15. Birthplace Pa.

16 (a) Informant Mrs. Lester Wallace
(b) Address 2204 Maryland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address North & Pa. Aves., Balto., Md.

19 (a) FEB 26 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25 1945, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/24 1945 to 2/25 1945, and that I last saw her alive on 2/25 1945

Immediate cause of death	Duration
Pulmonary Edema	1 day
Due to Hypertensive C.V. Disease	years
Due to	
Other Conditions (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l. Hospital Date signed 2/25/45

X

3 Copies.
G26265

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. G26265

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1618 Hartford Ave
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Hartford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Clark

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Horace W. Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1887

8. AGE: Years	Months	Days	If less than one day
58	0	12	hr. min.

9. Birthplace Pittsburgh Pa
(Town, county, and state)
10. Usual Occupation Housewife at Home
11. Industry or business

FATHER
12. Name Michael Mursfeby
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Ann Clifford
15. Birthplace 1618 Harford Ave

16 (a) Informant Mr. Horace W. Clark
(b) Address 1618 Harford Ave

17 (a) Burial (b) Date thereof Feb 28/1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Penn. Cathedral Cemetery
Location 4300 Rd Frederick Rd

18 (a) Funeral director Edmund W. Conklin
(b) Address 9242 Eager St.

19 (a) Huntington Williams M.D.
(Date received by registrar) FEB 26 1945 Registrar

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24 1945, at 11 25 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his or her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Hypertensive C V Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester S. Jablonski M.D.
Medical Examiner.
Date signed 2/25/45

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

3 626266 45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

37

626266 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 N. Monroe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 N. Monroe St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Victor a Sill

3 (b) If veteran, name war No

3 (c) Social Security Account No. 216-03-2424

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edwin M. Sill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5-1875

8. AGE: Years 69 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace Michigan (Town, county, and state)

10. Usual Occupation Gentleman

11. Industry or business

FATHER 12. Name Henry Sill

13. Birthplace Not Known

MOTHER 14. Maiden Name Elizabeth Terry

15. Birthplace N. Y.

16 (a) Informant Mrs Elsie M. Sill

(b) Address 211 N Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26/1945 (month) (day) (year)

(c) Cemetery or crematory London Park Cem

Location 3801 Frederick Rd

18 (a) Funeral director Elmer W. Conklin & Son

(b) Address 924 E. Eager St.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 26 1945

Huntington Williams

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22, 1945 at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9- 1945 to Feb 22 1945 and that I last saw h in alive on Feb 22 1945

Immediate cause of death	Duration
Coronary Thrombosis	2/22/45
Due to	
Due to Chr. Myocarditis	1935
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Bosomworth M.D.

Address 1636 Hunt Ave Date signed 2/23/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D Registered No. 626267

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Denison st
(c) Hospital or institution: The Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1901 Regester St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John P. Monaghan

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired Store Keeper
11. Industry or business

FATHER
12. Name Peter Monaghan
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Elwood
15. Birthplace Ireland

16 (a) Informant Family Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 27/43 (month) (day) (year)
(c) Cemetery or crematory Govt Cathedral
Location 4300 Rd Frederick Rd
18 (a) Funeral director Edmund W. Coughlin & Son
(b) Address 924 E. Eager St.
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23, 1943 at 6.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-13- 1943, to Feb-23- 1943. and that I last saw him alive on Feb 23- 1943.

Immediate cause of death	Duration
Edema Lungs	1 day.
Due to Chronic Myocarditis	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall
Address 1631 E. North Ave Date signed Feb 24-43 M. D.

FEB 26 1943

VS 150

X

PRINT WRITE PLAINLY, WITH UNFADING INK. Entry must be complete in every item. If any item is unknown, so state. Do not use ditto marks. Use black ink. Do not abbreviate except as directed. Do not write above or below lines. Do not fold. Use typewriter if possible. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

2 Jacobs
G66268

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 99

G66268
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution:
Univ Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Washington Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Burk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Louisa Burk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6, 1886

8. AGE: Years 58 | Months 6 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Sweet Air, Balto. Co., Md
(Town, county, and state)

10. Usual Occupation General Laboring
11. Industry or business Blacksmithing

FATHER
12. Name Andrew Burk
13. Birthplace Balto. Co., Md

MOTHER
14. Maiden Name Katherine Trefz
15. Birthplace Glenferrie Md

16 (a) Informant Mrs. Marjorie K. Bell
(b) Address 4404 Edmondson Ave

17 (a) Buried (b) Date thereof Feb. 27, 1945
(Burial, cremation, or removal) (month) (day), (year)

(c) Cemetery or crematory St. Johns Lutheran Cem
Location Sweet Air, Balto. Co., Md

18 (a) Funeral director Edgar H. Coulbourn & Son
(b) Address 924 E. Eager St.

19 (a) FEB 28 1945 Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23 1945, at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22 1945 to 2-23 1945, and that I last saw h[illegible] alive on 2-23-1945

Immediate cause of death Cardiac Failure
Pulmonary Edema — Duration
Due to Mesenteric Thrombosis
Due to Shock
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Mesenteric Thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Fauthouser M.D.
Address Univ Hosp Date signed 2-28-45

PLEASE WRITE PLAINLY, WITH PENCIL OR PEN. In reporting items 8 and 19, if exact age is not known, enter approximate age. Physicians: please write the causes of death clearly and legibly.

VS 150

1

626269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

626269 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mutual Insurance
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4251 Park Heights
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar Katzen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1890

8. AGE: Years 54 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Shoemaker

11. Industry or business

FATHER
12. Name Lasb
13. Birthplace Russia

MOTHER
14. Maiden Name Bluma
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jos Levin Inc
(b) Address 1432 E. Baltimore St

19 (a) (Date received) FEB 26 1945 (Registrar) Washington Williams MR

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1945, at 11:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 1945, to Feb 21 1945, and that I last saw him alive on Feb 21 1945.

Immediate cause of death Coronary Thrombosis - Pulmonary edema — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rachel Bachman M. D.
Address West Balt Gen Hosp Date signed 2/24/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940

G26270

Registered No. 4

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4206 PALL MALL ROAD

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 36yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4206 PALL MALL ROAD

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Hannah Feddeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Israel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Roppel Kutzman

13. Birthplace Russia

MOTHER

14. Maiden Name Kayla –

15. Birthplace Russia

16 (a) Informant Nathan Feddeman

(b) Address 4206 Pall Mall Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-45 (month) (day) (year)

(c) Cemetery or crematory Rehev Mt. Carmel

Location

18 (a) Funeral director Jacob Levin Inc

(b) Address 1439 E. Balto. St

19 (a) (Date rec'd by registrar) FEB 26 1945 (Registrar) Thornton Williams, M.D.

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26-45 19 , at 1 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1943, to 2/25 1945, and that I last saw h alive on 2/25 1945.

Immediate cause of death Heart disease

Due to Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
6 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Maurice Friedrich M. D.

Address 2125 Kendrick Date signed 2/26/45

X

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

626271 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 323 N. Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 323 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie T. Guinan

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
F.	W.	

6 (b) Name of husband or wife John T. Guinan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4-1870

8. AGE: Years 74 | Months 7 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Germany.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany.

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 2-27-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson ave

18 (a) Funeral director Kendall E. Humphreys.
(b) Address 1501 N. Broadway.

19 (a) FEB 26 1945
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23- 1945 at 6 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/21 19 45 to 2/23 19 45, and that I last saw him alive on 2/23 19 45.

Immediate cause of death — Hypostatic Pneumonia — Duration

Due to

Due to

Other Conditions Chronic Endo carditis
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hubert T. Gurley M. D.
Address 902 N Charles Date signed 2/26/45

Huntington Williams, M.D.

X

G66272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5-2C

G66272 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland North Broadway
(b) Street address ~~Church Home + Hosp.~~
(c) Hospital or institution:
Church Home + Hospital b'
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Md~~ (b) County ~~Baltimore~~
(c) City or town Church Home + Hosp.
(If outside city or town limits, write RURAL and give town)
(d) Street No. North Broadway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Emma Jane Burgess (nee Carroll)

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Fountain Meredith Burgess | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23-1863

8. AGE: Years 81 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Anne Arundel County
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name — Carroll
13. Birthplace —

MOTHER
14. Maiden Name Armanela Hawkins
15. Birthplace Maryland

16 (a) Informant Mrs. William R. Burgess
(b) Address 702 N. Appleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 (month) | 27 (day) | 45 (year)
(c) Cemetery or crematory Cedar Bluff
Location Annapolis, Md.

18 (a) Funeral director Wm. Wilson & Son
(b) Address 2503 Edmondson Ave

19 (a) FEB 28 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1945, at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1945 to Feb 23 1945 and that I last saw her alive on Feb 23 1945

Immediate cause of death	Duration
Heart failure.	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions Cerebral hemorrhage with metastases	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James B Lenaghan M. D.
Address The Church Home + Hosp. Date signed 2-23-45

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626273 626273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2759 FENWICK AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9/6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2759 FENWICK AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA A LETMATE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEM | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) MARCH 31 1881

8. AGE: Years 63 | Months 10 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace BALTO MD. (Town, county, and state)

10. Usual Occupation HAIR DRESSER

11. Industry or business SELF

FATHER
12. Name CHARLES F LETMATE
13. Birthplace BALTO MD

MOTHER
14. Maiden Name JULIA HOCK
15. Birthplace BALTO MD

16 (a) Informant MRS LYDIA ROCHESTER
(b) Address 2759 FENWICK AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-27-45 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTO MD

18 (a) Funeral director Mc Chas A Rohde
(b) Address 2327 EDMONDSON AVE

19 (a) ..... (b) ..... (Date rec'd by registrar) Registrar

FEB 26 1945 Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 25 1945, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20-1945 to 2-25-1945, and that I last saw h alive on 2-7-4-1945

Immediate cause of death: Carcinoma rectum with metastases — Duration: Uncon

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. B. Tyler M. D.

Address 2802 Harford Rd Date signed 2-26-45

PLEASE WRITE PLAINLY, with UNFADING INK. Entries must be complete. Give the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

G26274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G26274 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 W. Gilmor St.
(c) Hospital or institution: nu
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 624 W. Gilmor St. (If rural give location)
(e) Citizen of foreign country? nu (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Taylor Briggins.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Fem.

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm. Taylor

6 (c) If alive, give age: Not Ascertained years

7. Birth date of deceased (mo., day, yr.): June 29 1904

8. AGE: Years 40 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace: Leesville S C (Town, county, and state)

10. Usual Occupation: House Wife

11. Industry or business

FATHER
12. Name: Benjamin Mills
13. Birthplace: Spartanburg S.C.

MOTHER
14. Maiden name: Louise McClain
15. Birthplace: Leesville S C

16 (a) Informant: Benjamin Mills
(b) Address: 426 S. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26, 45 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Memorial
Location

18 (a) Funeral director: Mrs Katie R Williams
(b) Address: 3 Schroeder St

19 (a) FEB 26 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1945, at 2 Noon

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to Feb 21 1945.
and that I last saw h alive on Feb 21 1945

Immediate cause of death	Duration
Chronic Valvular Heart Disease	9 Months
Due to	
Due to Last Lemon	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation nu

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide nu
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signed John Shelton M. D.
Address 624 W. Gilmor Date signed 2/23/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 90B

626275 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 N. Stockton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Preston Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, (married) widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Richmond, Virginia
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Preston Johnson
13. Birthplace

MOTHER
14. Maiden Name Leonora
15. Birthplace

16 (a) Informant Mrs. Elizabeth Johnson
(b) Address 4 N. Stockton St.

17 (a) Burial (b) Date thereof Feb 27, '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) FEB 26 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22- 1945, at 11 45" A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhage cerebrum
Apoplexy
Due to Aortic Lesion

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 2-23-45

VS 151

Cover up to keep any imprints. Typewrite; please write the causes of death clearly and legibly.

G26276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33 D

G26276 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2205 Homewood Ave
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 Homewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosetta Barbara Krauch

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-2549

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31/1894

8. AGE: Years 50 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Saleslady

11. Industry or business Statzler & Bros

FATHER 12. Name William Krauch

FATHER 13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Katherine Hebner

MOTHER 15. Birthplace Baltimore Md

16 (a) Informant James N. Wells

(b) Address 2205 Homewood Ave

17 (a) Burial (b) Date thereof Feby 27/1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn Md

18 (a) Funeral director Ellsworth Memorial

(b) Address 3911 Liberty Heights Ave

19 (a) (b) Huntington Hollins
(Registrar)

FEB 26 1945
VS 11e

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1945 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 19 1945 to Feb 24 1945 and that I last saw h e alive on Feb 23 1945

Immediate cause of death	Duration
Influenza with Heart Failure	5 days
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anna L. Abercrombie M. D.

Address 3524 Greenmount Ave Date signed 2/24/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626277 BALTIMORE CITY HEALTH DEPARTMENT 626277
CERTIFICATE OF DEATH
Registered No. 94

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Upperco - (Rural) (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leydia ELLA FRINGER
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband ~~or wife~~ George J Fringer
6 (c) If alive, give age 76 years
7. Birth date of deceased (mo., day, yr.) March 17-1868
8. AGE: Years 76 | Months 11 | Days 9 | If less than one day ____ hr. ____ min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name Samuel Powell
13. Birthplace Maryland
MOTHER 14. Maiden Name Lydia Light
15. Birthplace Maryland
16 (a) Informant Mrs Leslie Wheeler
(b) Address Hampstead, Md
17 (a) burial (Burial, cremation, or removal) (b) Date thereof Mar 1/45 (month) (day) (year)
(c) Cemetery or crematory St Paul's
Location Balto Co
18 (a) Funeral director Edw S Tipton
(b) Address Hampstead Md
19 (a) (Date rec'd by registrar) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION
20. DATE OF DEATH 2-26 1945, at 9 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 1-20 1945 to 2-26 1945, and that I last saw her alive on 2-25 1945
Immediate cause of death Cardiac failure — Duration
Due to Coronary disease + Chronic pulmonary infarct
Due to
Other Conditions Uremia + Chronic hydrothorax (bilat.)
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature P Lippmann M.D.
Address Univ Hosp Date signed 2-26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be complete in all items. Be sure to write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write

FEB 26 1945
VS 180

26278

469208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

60

Registered No. 26278

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Wolfe Sts.
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 N. Appleton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Hewitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-24-93

8. AGE: Years	Months	Days	If less than one day
51	8	29	hr. min.

9. Birthplace Penn.
(Town, county, and state)
10. Usual Occupation Hospital Employ.
11. Industry or business

FATHER
12. Name Allen Hewitt
13. Birthplace England.

MOTHER
14. Maiden Name Emma Duncan
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (b) Date thereof 2-26-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory United Brethren
Location Greenmount Carroll Co. Md.

18 (a) Funeral director Harry A Witzke
(b) Address 2101 Edmondson Ave

19 (a) FEB 26 1945 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS .150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1945, at 7.34 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 19. 1945 to Feb. 23 1945, and that I last saw h[illegible] alive on Feb. 23 1945.

Immediate cause of death Respiratory Failure — Duration

Due to Adenocarcinoma Rt breast & Adenocarcinoma thyroid — 2 yrs. 4 yrs.

Due to both metastases & lung & pleura

Other Conditions Cyanosis & cardiac failure. Pleural effusion

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Abraham Geneser M. D.
Address Johns Hopkins Hosp Date signed 2-23-45

G26279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G26279 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BUCKINGHAM ARMS, 3706 N.CHARLES ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL, and give town)
(d) Street No. 3706 N. CHARLES ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN BURCHINAL HINES

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife HELEN B. WEBB
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28.1875

8. AGE: Years	Months	Days	If less than one day
69	6	26	hr. min.

9. Birthplace CHESTERTOWN MD. (Town, county, and state)
10. Usual Occupation clerical, retired
11. Industry or business

FATHER
12. Name JOHN HINES
13. Birthplace MD.

MOTHER
14. Maiden Name ELIZABETH
15. Birthplace MD.

16 (a) Informant ROBERT T. GREER
(b) Address SYKESVILLE MD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEBY 26.1945 (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE CEMETERY
Location PIKESVILLE MD.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 EUTAW PLACE

19 (a) Huntington Williams M.D. (Registrar)
(b) Date Received FEB 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 23.1945 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 21 1945, to Feb 23 1945, and that I last saw h in alive on Feb. 22 1945.

Immediate cause of death	Duration
Coronary occlusion	10 min.
Due to Advanced Arterio sclerosis	?
Due to	
Other Conditions Pulmonary edema	1 day

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hallie Bishop M. D.
Address 2220 GARRISON BOULEVARD Signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G26280

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 756 W Saratoga St
(c) Hospital or institution: 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs 6 m

2. USUAL RESIDENCE OF DECEASED:
(a) State Georgia (b) County Musco Co
(c) City or town Columbus Ga.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 326 25th street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Louise Carpenter

3 (b) If veteran, name war

3 (c) Social Security Account No. 253-14-7693

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	married

6 (b) Name of husband or wife Louise Carpenter
6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) 6/1914

8. AGE: Years	Months	Days	If less than one day
30 yr	8		hr. min.

9. Birthplace Musco Co. Georgia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Allen Carpenter
13. Birthplace Musco Co. Georgia

MOTHER
14. Maiden Name Rena Johnson
15. Birthplace Musco Co Georgia

16 (a) Informant Winfred Patrick
(b) Address Musco Co. Georgia

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 2 28 1940 (month) (day) (year)
(c) Cemetery or crematory Prospect Mem.
Location Musco Co Georgia

18 (a) Funeral director Mrs Ida Bailey
(b) Address 142 Jefferson St

FEB 26 1940 Date rec'd by registrar — Huntington Williams Asst. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24th 1940, at 7.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16-1940 to 2-24-1940, and that I last saw h alive on 2-23-1940.

Immediate cause of death	Duration
Lobar Pneumonia	7 Days
Due to	
Due to Influenza Pneumonia	
Other Conditions Bad Kidney (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D Grant Jeffries M. D.
Address 324 W. Biddle St Date signed 2-24-40

VS 150

X Scott

G26281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 32

G26281 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2855 Mayfield Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2855 Mayfield Ave
(If rural give location)
(e) Citizen of foreign country? N (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas Appel.

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widower.

6 (b) Name of husband or wife: Mary Appel.

6 (c) If alive, give age years

7. Birth date of deceased, mo., day, yr.: Aug 21, 1861

8. AGE: Years 83 | Months 6 | Days 3 | Unless less than one day hr. min.

9. Birthplace: Maryland.
(Town, county, and state)

10. Usual Occupation: Retired Tailor.

11. Industry or business

FATHER
12. Name: Edward Appel
13. Birthplace: Germany.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown.

16 (a) Informant: Louis E. Appel
(b) Address: 2855 Mayfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb 29/45 (month) (day) (year)

(c) Cemetery or crematory: Baltimore
Location

18 (a) Funeral director: Emanuel P. Bonvouloir
(b) Address: 3615-17 Chestnut Ave

19 (a) (Date received by Registrar) FEB 26 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 24, 1945, at 9:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1- 1945, to 2-24 1945, and that I last saw him alive on 2-23 1945.

Immediate cause of death	Duration
Cerebral Apoplexy	24 days
Due to: Generalised arteriosclerosis	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Melton C. Lacy M. D.
Address: 2117 Belair Rd Date signed: 2-26-45

626282 | BALTIMORE CITY HEALTH DEPARTMENT | 626282

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2228 Monumental Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Parker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	M.

6 (b) Name of husband or wife Catharine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 25, 1880

8. AGE: Years	Months	Days	If less than one day
64	3	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Night Watchman
11. Industry or business Oil IND.

FATHER
12. Name JOHN PARKER
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name JANE McGAHA
15. Birthplace VIRGINIA

16 (a) Informant WILLIAM J. PARKER
(b) Address 524E FORT AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-27-45 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location RITCHIE HIGHWAY

18 (a) Funeral director C. RAYMOND KAUFMAN
(b) Address 1026 LEEDS AVENUE

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 26 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23 1945 at 10:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/22 1945 to 2/23 1945 and that I last saw h/m alive on 2/23 1945

Immediate cause of death Myocardial Insufficiency — Duration
Due to Ped Coma, Infection
Due to
Other Conditions Lobular pneumonia & Dehydration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clk Pratt Jr. M.D.
Address St Agnes Hospital Date signed 2/27/45 M.D.

X

626283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

626283 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 2733 Chesterfield (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Mrs~~ Gertrude C. Boegner Boegner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Charles Boegner

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Dec. 21-1895

8. AGE: Years 49 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace Balto - Md (Town, county and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Clement Athmann

13. Birthplace Germany

MOTHER 14. Maiden Name Agnes Fell

15. Birthplace Md

16 (a) Informant Mrs. Charles Boegner

(b) Address 2733 Chesterfield

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore

18 (a) Funeral director Leonard J. Luck

(b) Address 5366 Harford Rd

19 (a) (Date received by Registrar) (b) Registrar

FEB 26 1945

Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24 1945 at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20 1945 to 2/24 1945. and that I last saw her alive on 2/24 1945.

Immediate cause of death Cardiac Respiratory failure — Duration

Due to Poss. Cerebral Hemorrhage

Due to Hypertension C.V.D.

Other Conditions Diabetes Mellitus + Cellulitis of Legs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert B. McFaddin M.D.

Address St Josephs Hosp. Date signed 2/24/45

43D

G26284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G26284
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2002 Girard Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 Girard Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Louella Harrison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Ulysses S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 1864

8. AGE: Years	Months	Days	If less than one day
80	8	17	hr. min.

9. Birthplace Ohio
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Albert Burk
13. Birthplace Ohio

MOTHER
14. Maiden Name Margaret Jones
15. Birthplace Ohio

16 (a) Informant Mrs Zola Bowersox
(b) Address 2002 Girard Ave

17 (a) Burial (b) Date thereof 2-27-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rockwood
Location Baltimore Md.

18 (a) Funeral director L. J. Funk
(b) Address 3306 Harford Rd.

19 (a) (b) Registrar
(Date rec'd by registrar)

FEB 26 1945

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1945, at 10 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 19 1945 to Feb 24 1945, and that I last saw her alive on Feb 20 1945

Immediate cause of death	Duration
Acute Cardiac dilatation	sudden
Due to Cardio-Vascular disease.	10 yrs
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Jason Duvall.
Address 846 W 36th St. Date signed 2/24/45.

Huntington Williams, M.D.

3318 Mc Elderry

G26285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1942

G26285 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2826 Kentucky Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2826 Kentucky Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Adam E. Bittner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Matilda L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8 - 1875

8. AGE: Years	Months	Days	If less than one day
69	9	17	hr. min.

9. Birthplace Columbia - Pa. (Town, county, and state)

10. Usual Occupation Retired Police

11. Industry or business

FATHER

12. Name Peter Bittner

13. Birthplace Columbia, Pa.

MOTHER

14. Maiden Name Sophia

15. Birthplace

16 (a) Informant Mrs. Peter Bittner

(b) Address 306 Woodbourne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Road

19 (a) FEB 26 1945 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1945, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 19 43 to Feb 25 1945, and that I last saw him alive on Feb 25 1945.

Immediate cause of death Arteriosclerosis — Duration 5 Yrs

Due to Angina Pectoris. — 2 Yrs

Cerebral Hemorrhage — 1 Day

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature James F Kenny M.D.

Address 3318 Mc Elderry Pa Date signed 2-26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

626286 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. Balto. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Clarksville
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Hobbs Manahee

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Sallie Manahee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/7/1862

8. AGE: Years 82 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace Clarksville Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name John Manahee

13. Birthplace Clarksville, Md

MOTHER 14. Maiden Name Margaret Hobbs

15. Birthplace Md.

16 (a) Informant Mary Alda Gardener

(b) Address Clarksville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-45 (month) (day) (year)

(c) Cemetery or crematory Ft Lapus

Location Clarksville Md

18 (a) Funeral director J.C. Degenhardt

(b) Address Ellicott City Md

(c) Date received FEB 26 1945 (Registrar) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24th 1945, at 4 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2 1945, to 2-24 1945, and that I last saw him alive on 2-24 1945.

	Duration
Immediate cause of death Myocardial failure	
Due to Hypertens. C-V Dis	
Due to	
Other Conditions Thrombophlebitis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. L. O. Tucker M.D.

Address Mercy Hosp. Date signed 2/24/45

G26287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 138

Registered No. G26287

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1520 Thames st.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 Thames st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PETER BAILOVICH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-13-1904

8. AGE: Years	Months	Days	If less than one day
40 39	9	12	hr. min.

9. Birthplace YUGOSLAVIA (Town, county, and state)

10. Usual Occupation BARBER

11. Industry or business

FATHER
12. Name STANLEY BAILOVICH
13. Birthplace YUGOSLAVIA

MOTHER
14. Maiden Name STELLA RADMANOVICH
15. Birthplace YUGOSLAVIA

16 (a) Informant STELLA BAILOVICH MOTHER
(b) Address 1520 THAMES ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-45 (month) (day) (year)
(c) Cemetery or crematory HOLY TRINITY RUSSIAN
Location STONY RUN Md AACO.

18 (a) Funeral director George A Weber
(b) Address 705 S Carey Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

FEB 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 25th 1945, at 9:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1945 to Feb 25 1945, and that I last saw him alive on Febry 24 1945.

Immediate cause of death Pulmonary Tuberculosis — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Silverstein

Address 27 S. Broadway Date signed M/D. 2/26 1945

G26288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G26288 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Carolvie St.
(c) Hospital or institution St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2819 Alvarado Square
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary E. Salisbury

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Charles A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23 1875

8. AGE: Years	Months	Days	If less than one day
#69	7	2	hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mr Walter S. Salisbury
(b) Address 2819 Alvarado Sq.

17 (a) Burial (b) Date thereof 2-28-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Road

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25 1945, at 6.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24 1945, to 2-25 1945, and that I last saw h[illegible] alive on 2-25 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to arteriosclerotic c.v.d.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Josephs Hosp. Date signed 2-25-45

G26289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G26289

Every item or information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 324 S. Ann St. City 31
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB JOSEPH MECHLINSKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife. ~~wife~~ MARY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7 1892

8. AGE: Years 52 | Months 7 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Storekeeper

11. Industry or business

FATHER
12. Name Joseph J. Mechlinski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Zborowski
15. Birthplace Poland

16 (a) Informant Mrs. Josephine Grat GRAT
(b) Address 324 S. Ann St; City 31

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 27/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore County

18 (a) Funeral director John M. Welby
(b) Address 401 S. Chester Street

19 (a) FEB 26 1945 Date received by registrar (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 1945, at 5:3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 24 1945 to Feb. 24 1945, and that I last saw him alive on Feb 24 1945.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Cerebral accident (stroke)	
Due to Hypertensive cardio-vascular disease	
Other Conditions Anemia, actiology unknown	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, M.D.
Address Union Memorial Hospital Date signed 2/24/45

VS 150

G26290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G26290 108 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 339 S Monroe
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 339 S Monroe (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen M Nixon

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Joseph V
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 5 1902

8. AGE: Years	Months	Days	If less than one day
42	10	19	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph J Rawlings
13. Birthplace Md

MOTHER
14. Maiden Name Mary H Foster
15. Birthplace Md

16 (a) Informant Joseph V Nixon
(b) Address 339 S Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Geo A Tawney
(b) Address Fulton & Fayette

19 (a) (b) Huntington Maryland

FEB 26 1945 Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1945, at 4a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1945, to Feb 24 1945, and that I last saw h alive on Feb 23 1945

Immediate cause of death	Duration
Lobar Pneumonia	7 days
Due to	
Due to	
Other Conditions Pleural Effusion	7 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James K Kennedy M.D.
Address 721 Medical Arts Bldg Date signed 2/26/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

626291 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 S. Broadway St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James W Rowley.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9-1-27.
8. AGE: Years 17 Months 5 Days 27 If less than one day ..... hr. ..... min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation School.
11. Industry or business

FATHER
12. Name Charles Rowley
13. Birthplace Va.

MOTHER
14. Maiden Name Lillian McKee
15. Birthplace ?

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 2/27/45 (month) (day) (year)
(c) Cemetery or crematory Leidy Heal
Location Blank by Mr. James W. McCully
18 (a) Funeral director
(b) Address
FEB 26 1945
19 (a) (Date rec'd by registrar) (b) Registrar Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1945, at 9.57 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1945 to Feb. 23 1945 and that I last saw him alive on Feb. 23 1945.

Immediate cause of death Uraemia — Duration
Due to Renal insufficiency
Due to Diphtheria
Other Conditions Diabetes, nephritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Albert A. Hatton M.D.
Address Johns Hopkins Hosp. Date signed 2/27/45

VS 150

Correct age in capitals. Physicians: please write the causes of death clearly and legibly.

66232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1706

Registered No. 66232

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Street
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3311 Elbert Street (If rural give location)
(e) Citizen of foreign country? Na (Yes or No)
If yes, name country —

3 (a) FULL NAME William T. Chance

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213052950

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mildred E. Chance
6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) August 18, 1915

8. AGE: Years	Months	Days	If less than one day
29	6	8	— hr. — min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Chauffer
11. Industry or business Koontz Dairy

FATHER
12. Name Wm. T. Chance
13. Birthplace Maryland

MOTHER
14. Maiden Name Nellie E. Murphy
15. Birthplace Maryland

16 (a) Informant Mildred E. Chance
(b) Address 3311 Elbert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Fred. Rd. Irvington

18 (a) Funeral director F. B. Wippert & Son
(b) Address 1300 Eutaw Place

19 (a) FEB 28 1945 (Date Received by Local Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 1945 at 2:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull
Ruptured Spleen

Due to —

Other Conditions Multiple fractures
lacerations, abrasions & bruises

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/25/45 at 8/1 2:15 P.M.
(b) Where did injury occur? Harford Rd near Walbrook Blvd.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Collision 2 autos and auto

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 2-25-45

626293

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

626293
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 902 Compton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 Compton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph James Edward Day.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male
5. Color or race W.
6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Nancy A. Day
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July - 1870

8. AGE: Years 71 | Months 7 | Days | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Day
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace Md

16 (a) Informant Herman H. Day
(b) Address 104 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto. Md.

18 (a) Funeral director F. H. WIPPERT'S SON
(b) Address 850 W. Baltimore, Md.

19 (a) ____ (b) ____
(Date rec'd by registrar) FEB 26 1945 Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 1945, at 5.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2.17. 1945 to 2.24 1945; and that I last saw him alive on 2.24 1945.

Immediate cause of death	Duration
Thrombosis of Coronary artery	2 days.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Norris M.D.
Address 1 E. East West St Date signed 2.24.45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626294
468689.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

106 B

Registered No. 626294

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Worcester
(c) City or town Bishop-
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dolly Hemphill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female.	White.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-29-16.

8. AGE: Years	Months	Days	If less than one day
28	4	27	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Hemphill
13. Birthplace ? ?

MOTHER
14. Maiden Name Millie Hemphill
15. Birthplace ? ?

16 (a) Informant Rev. nds.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Feb 28 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Dodd.
Location Bishopville, Md.

18 (a) Funeral director M Parks Watson
(b) Address Bishopville, Md.

19 (a) 26 1945 (Name) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26- 1945, at 7.35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-9 1945, to Feb-26 1945, and that I last saw him alive on Feb-26- 1945.

Immediate cause of death	Duration
Pneumonectomy	
Due to Bronchiectasis	
Due to	
Other Conditions Hypertension; pleural effusion; ? pulmonary edema	

(Include pregnancy within 3 months of death)

Date of operation 2/23/45

Major findings of Operation: Bronchiectasis Right Lung.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J C Vandeliman M. D.
Address JHH Date signed 2-26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G26295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G26295

Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2209 W. Lexington St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town 2209 W. Lexington St.
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Kate Anna GRIMES

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John W. Grimes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 8, 1866

8. AGE: Years 78 | Months 7 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace: Howard Co., Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Henry Ripley
13. Birthplace: Germany

MOTHER
14. Maiden Name: ~~[illegible]~~ Schaeffer
15. Birthplace: Germany

16 (a) Informant: Mrs. Gertrude Stern

(b) Address: Ellicott City, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/45 (month) (day) (year)

(c) Cemetery or crematory: Good Sheppard

Location:

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 26 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23, 1945 at 3:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/18 1945 to 2/23 1945.
and that I last saw her alive on 2/23 1945.

Immediate cause of death	Duration
Bronchopneumonia	2da
Due to Generalized arteriosclerosis CV Disease	10yr
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Joseph G Laukaitis M.D.

Address 6 W Washington Blvd Date signed 2/26/45

(over)

G26296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G26296 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2813 E. Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2813 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James B. Roddy
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Annie B. Roddy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept - 28 - 1875

8. AGE: Years	Months	Days	If less than one day
69	4	26	Hr. min.

9. Birthplace Balty. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Railway Express

FATHER
12. Name Thomas F. Roddy
13. Birthplace Ireland

MOTHER
14. Maiden Name Brigid Lynam
15. Birthplace Ireland

16 (a) Informant Mrs Genevieve Bozato
(b) Address 2813 E Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Ply J. Reilly Fac
(b) Address 243 E Oliver St

FEB 26 1945 (b) Huntington Woods, Mich.
(Registered by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 24 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/26 1945 to 2/24 1945, and that I last saw h alive on 19

Immediate cause of death	Duration
Pulmonary Edema	6hrs
Due to Chronic Myocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Floyd D. Fidler M. D.
Address 3373 E Baltimore Date signed 2/26/45

G26297 BALTIMORE CITY HEALTH DEPARTMENT G26297

CERTIFICATE OF DEATH 92D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2524 E. Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give location)
(d) Street No. 2524 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Bleuel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Johanna M. Bleuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7 1875

8. AGE: Years	Months	Days	If less than one day hr.	min.
69	9	17		

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business Unemployed

FATHER
12. Name Erhardt Bleuel
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Moellrich
15. Birthplace Germany

16 (a) Informant Johanna M. Bleuel
(b) Address 2524 E. Biddle St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2-27-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John C. Miller Inc
(b) Address 2435 E. Oliver St

19 (a) (Date rec'd by reg.) (b) Livingston Williams, Registrar

FEB 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24 1945, at 6a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/19 1944 to 2/24 1945, and that I last saw h[illegible] alive on 2/23 1945

Immediate cause of death

Duration
2 yrs

Due to Cerebral Vascular Accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
. Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 2/26/45 M. D.

X

Dr Bagli
G26298

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G26290
93a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5212 Harford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5212 Harford Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew J. Krein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary F. Krein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12-1880

8. AGE: Years 65 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation Manufacturers Supplies
11. Industry or business Jeff- and Lloyd

FATHER
12. Name Frankfis Kreiss
13. Birthplace Md.

MOTHER
14. Maiden Name Anna M. Huber
15. Birthplace Md.

16 (a) Informant Mrs. Mary F. Krein
(b) Address 5212 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Lugh
(b) Address 5303 Harford Rd.

19 (by) J. Huntington Williams M.D. (Local registrar) Registrar

FEB 28 1945
Vs No 45

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 - 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 19 1945, to Feb 23 1945, and that I last saw h[im] alive on 2/23 1945

Immediate cause of death: Acute Myocarditis — Duration: 3 days
Due to
Due to
Other Conditions Emphysema
Chr. Bronchitis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frances L. Bagli
Address 6077 Harf. Rd Date signed M. D. 2/26/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G26299 ✓ G26299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3201 Mary Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Mary Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Eisenreich

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh	W

6 (b) Name of husband or wife Margaret Imhoff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27th, 1858

8. AGE: Years	Months	Days	If less than one day
86 87	5	27 29	hr. min.

9. Birthplace Monkton, Balto. Co., Md.
(Town, county, and state)
10. Usual Occupation Meat inspector (retired)
11. Industry or business

FATHER
12. Name Joseph Eisenreich
13. Birthplace Munich, Germany

MOTHER
14. Maiden Name Barbara Machwirt
15. Birthplace Munich, Germany

16 (a) Informant Mrs. Sophie Norwood
(b) Address 3201 Mary Ave.

17 (a) Burial (b) Date thereof 2/28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Pk.
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (b)
(To be filled in by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-4- 1945, to 2-24- 1945, and that I last saw h im alive on 2-24- 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	3 days
Due to Arteriosclerosis	Many yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Wilkinson
A. L. Wilkinson, M. D.
Address 5713 Bel Air Rd. Date signed 2-26-45

X

G26300 ✗ ✓G26300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, ~~Maryland~~
(b) Street address BALTIMORE, MARYLAND
(c) Hospital or institution:
Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Raspeburg RURAL
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 22
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Robertson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married~~, ~~widowed~~, or ~~divorced~~
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Leesville Va
(Town, county, and state)

10. Usual Occupation Lorane Operator

11. Industry or business Norfolk & Western R.R.

FATHER
12. Name John Robertson
13. Birthplace Leesville Va

MOTHER
14. Maiden Name Anna E Jackson
15. Birthplace Leesville Va

16 (a) Informant Martin J Drage
(b) Address Trumpsville Rd Raphine

17 (a) Burial (b) Date thereof 2-27-1945
(Burial, ~~cremation~~, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Leesville Va

18 (a) Funeral director Leo G. Cook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

FEB 26 1945

BVS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25 1945, at 10 A.M. 20

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
1st 2nd 3rd degree
Burns Face, arms, trunk.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/23/45 at 1:45 P. M. C. St.
(b) Where did injury occur? Home - Route 22.
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No
(d) Means of injury Cigarette ignited bedclothes,

23. Signature Eugene B. Mitchell M.D.
Medical Examiner.
Date signed 2/26/45

626301 TRUMBO

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 626301

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 4008 Fairmount Av
(b) Street address Balto Md
(c) Hospital or institution: ✓ 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 85 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town).
(d) Street No. 4008 Fairmount Av (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Selmon Trumbo

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nora Rodgers Trumbo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/10/1859

8. AGE: Years	Months	Days	If less than one day
85	5	16	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Linotype Operator
11. Industry or business

FATHER
12. Name Columbus Adam Trumbo
13. Birthplace Balto Md

MOTHER
14. Maiden Name Susan Hoover
15. Birthplace Balto Md

16 (a) Informant Mrs. H. Norbert Paul Jr
(b) Address Buckingham Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto Md

18 (a) Funeral director Walter Brooks Bradley Inc
(b) Address 1917 W. North Ave

19 (a) FEB 27 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1945 at 8 20 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22 1945, to Feb 25 19, and that I last saw him alive on Feb 24 1945

Immediate cause of death	Duration
Pneumonia Thrombosis	1 day
Due to Advanced arteriosclerosis	about 5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death ~~was due to external causes~~, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter S Tebbett M. D.
Address 2220 Garrison Blvd Date signed Feb 26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G26302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1829 N. Register st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1829 N. Register st
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna M. Davey

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-4680

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband or ~~wife~~: Thomas G. Davey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22nd 1895

8. AGE: Years 49 | Months 8 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business Oriole Sports Wear

FATHER
12. Name George Horstman
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Vetra
15. Birthplace Md

16 (a) Informant Thomas G. Davey
(b) Address 1829 N. Register St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/28/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1212 St. Paul St.

19 (a) FEB 27 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24th 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from October 10 1944 to Feb 24 1945, and that I last saw her alive on February 24 1945.

	Duration
Immediate cause of death: Carcinoma of Uterus	6 months
Due to:	
Due to:	
Other Conditions: Cachexia and Metastasis (Include pregnancy within 3 months of death)	1 Hr. Days.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Eisenberg M. D.
Address 2025 E. Northdale Date signed 3/25/45

X

M 26303 -

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. M 26303

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3706 W. Belvedere Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 W Belvedere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Giesler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Gustav W. Giesler
6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1868

8. AGE: Years	Months	Days	If less than one day
76	5	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Hamilton Jones
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma L. Browning
15. Birthplace Baltimore Md.

16. (a) Informant Mrs. Austin Semler
(b) Address 3706 W Belvedere Ave

17 (a) Burial (b) Date thereof 2-27-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Lasing Bogers
(b) Address 5005 Park Heights Ave

19 (a) (b)
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1945, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/25 1944 to 2/25 1945 and that I last saw h[illegible] alive on 2/25 1945.

Immediate cause of death	Duration
Chronic Myocarditis	1 yr.
Due to Coronary Sclerosis	1 yr.
Art. Sclerosis	5 yrs.
Due to	

Other Conditions Gastric Hemorrhage 2/24/45
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James A. Miller M. D.
Address Pikesville-8 Md Date signed 2/27/45

VS 150

626304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D ✓

Registered No. 626304

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 735 E. 22nd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 735 E. 22nd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Noble L. Riley

3 (b) If veteran, name war: W

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Mary E. Riley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 6th 1888

8. AGE: Years	Months	Days	If less than one day
56	3	18	hr. min.

9. Birthplace Harford Co. Md
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Self

FATHER
12. Name William C. Riley
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Estella James
15. Birthplace Md

16 (a) Informant Mary E. Riley
(b) Address 735 E. 22nd St

17 (a) Burial (b) Date thereof 2/27/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Friendship
Location Fallston Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) FEB 27 1945 (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24 1945 at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/23 1945 to Feb 24 1945 and that I last saw him alive on Feb 24 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to	
Due to	
Other Conditions Valvular Heart disease	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Janet Fisher M. D.
Address 1823 N. Charles St. Date signed 2/26/45

VS 150

83a

G26305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 a

G26305 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3702 Manchester Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3702 Manchester Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis F. Becker

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-1296

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Pearl Becker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13th 1888

8. AGE: Years	Months	Days	If less than one day
56	7	14	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired Watchman

11. Industry or business Standard Oil Co.

FATHER
12. Name Louis Becker
13. Birthplace Md.

MOTHER
14. Maiden Name Ida Zimmerman
15. Birthplace Md.

16 (a) Informant Pearl Becker
(b) Address 3702 Manchester Ave

17 (a) Burial (b) Date thereof 2-28-45
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (b)
(Signature and address of informant)

FEB 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24th 1945, at 10 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1942 to Feb 24 1945, and that I last saw h~~im~~ alive on 2-24 1945.

Immediate cause of death Pulmonary Oedema — Duration 5 Ds.

Due to Cardio-Renal Disease — Duration unknown

Due to — Duration

Other Conditions Hypertension — Duration unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. D. Ennis M. D.

Address 7201 Park Rd. Date signed 2-26-45

Form—12-23-21—E.B.R.S.—400 Blks.

Ada Bittinger Morgan ✓

626306 HEALTH DEPARTMENT—CITY OF BALTIMORE 626306

CERTIFICATE OF DEATH. 93D

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. 616 S. Fait Ave. Ward)

2-FULL NAME. Ada Bittinger Morgan (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 616 S Fait Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Charles F. Morgan

6-DATE OF BIRTH (month, day and year) Dec 25th 1894

7-AGE, 50 yrs. 2 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED.

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9-BIRTHPLACE (city or town) (State or Country), Pa

PARENTS.

10-NAME OF FATHER, George Bittinger

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Pa.

12-MAIDEN NAME OF MOTHER, Margaret Maloy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa.

14-

(Informant) Charles F. Morgan

(Address) 616 Fait Ave

15- FEB 27 1945 Huntington, W. Va.

Filed Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2/25/45

17- I HEREBY CERTIFY, That I attended deceased from 1/1 45, 19.. to 2/26, 19 45

that I last saw h.e.r. alive on 2/25, 19 45

and that death occurred, on the date stated above, at 11 55 p.m.

The CAUSE OF DEATH* was as follows: Cerebral

a Hemorrhage

Duration 2 mos 5 ds

CONTRIBUTORY (Secondary) Hypertension

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 4 E 3 Dr

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF ~~BURIAL, CREMATION OR~~ REMOVAL, Lewistown, Pa DATE OF BURIAL, Feb 28 1945

20-UNDERTAKER, William Cook Inc ADDRESS 117 St. Paul St.

G26307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G26307

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 852 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stephen Rothen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 71 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 26 1945
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) FEB 27 1945 Huntington Williams M.D. Registrar
(Date reg'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/16 1945, 2:00 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Leopold B. Zeidman M.D.
Medical Examiner.

Date signed 2/15/45

12540

G26308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH P3a

Registered No. G26308

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Flint ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 209 News ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gus Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1840

8. AGE: Years	Months	Days	If less than one day
55 ?			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 26 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 27 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 1945, at 2 20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Le Fraser M.D.
Medical Examiner.
Date signed Feb. 13 1945

2589

X

6309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

G26309 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 329 N. Gilmor Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 329 N. Gilmor Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Etta Pickett 15216

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/5/45

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 26 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 27 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7, 1945 at 9:25 A. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atelectasis, prematurum

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D.
Medical Examiner.
Date signed February 7 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

2538

6310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G26310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME June J. Seay

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 26 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 27 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1945, at 4:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subdural hematoma, right

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb 15 at 4 M.
(b) Where did injury occur? Fall
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Le Graham M.D.
Medical Examiner.
Date signed Feb 18 1945

VS 151

12541

G26311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G26311 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 2206 Eagle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Eagle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. R. May Sr.

3 (b) If veteran, name war None

3 (c) Social Security Account No. 212-10-7749

4. Sex M

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Helen R May

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) July 19 - 1885

8. AGE: Years 59 | Months 7 | Days 7 | If less than one day hr. min. 1945

9. Birthplace Baltimore Md
(Town, county and state)

10. Usual Occupation Electrician

11. Industry or business

FATHER
12. Name Frederick May
13. Birthplace Unknown

MOTHER
14. Maiden Name Rose Davis
15. Birthplace Unknown

16 (a) Informant Helen R. May
(b) Address 2206 Eagle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 28 - 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore City

18 (a) Funeral director Lott & B. M. Walter
(b) Address Pratt & Strecker Sts

19 (a) FEB 27 1945 (Date received by local registrar) Huntington Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26 1945, at 9:25 P M

21. I certify that I took charge of the remains described above, held an Autopsy - Inspection - Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester F. Lutkunas M.D.
Medical Examiner.
Date signed 2/26/45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26312 X ✓ G26312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Turner Sta.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 304 King Court
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME (Not named) Baby Boy Jerry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	New born

6 (b) Name of husband or wife —

6 (c) If alive, give age 0 years

7. Birth date of deceased (mo., day, yr.) 2/20/45

8. AGE: Years | Months | Days | If less than one day 1 hr. 55 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Bozye Grant Jerry
13. Birthplace Florence, S.C.

MOTHER
14. Maiden Name Mary Eliza Brown
15. Birthplace Florence, S.C.

16 (a) Informant Mother; Mary Jerry
(b) Address 304 King Court, Turner Sta.

17 (a) City disposal (Burial, cremation, or removal) (b) Date thereof 2 21 45 (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL FEB 26 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 27 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 10 P.M.

20. DATE OF DEATH 2/20 1945 at ~~8:05 P.~~ M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8:05 P.M. 2/20 1945 to 10 A.M. 2/20 1945 and that I last saw h.i.m. alive on 2/20 1945.

Immediate cause of death	Duration
Premature birth	
Due to Cause unknown	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature O. R. Ewing M.D.
Address Univ. Hosp. Date signed 2/20/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 2

2544 X

626313 Sweigal BALTIMORE CITY HEALTH DEPARTMENT ✓ 626313

CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 S Mon. Yfor dth
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 S. Mon Yfor dth (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leon · Sweigal

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24-45

8. AGE: Years | Months | Days | If less than one day hr. 20 min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Chester Leon Sweigal
13. Birthplace Chicago Ill

MOTHER 14. Maiden Name Helen Gratowski
15. Birthplace Baltimore

16 (a) Informant Helen Sweigal
(b) Address 605 S. Mon Yfor dth

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL FEB 26 1945

18 (a) Funeral director Commissioner of Health
(b) Address

FEB 27 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1945, at 8 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1945 to Feb 24 1945, and that I last saw h— alive on Feb 24 1945

Immediate cause of death	Duration
Premature birth	36 M
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William T. Reamer M. D.
Address 501 N Kenwood Date signed 2/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

2543 X

6314

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

30F Registered No. G26314

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use black ink and write the cause of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3111 Elm Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Mulcahy.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 | 8 | 45

8. AGE: Years | Months 1 | Days 5 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Waggaflarle
13. Birthplace Italy

MOTHER
14. Maiden Name Ruth Mulcahy
15. Birthplace Md.

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL FEB 26 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 27 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2.23 1945, at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-17 1945 to 2.23 1945, and that I last saw h alive on 2.23 1945.

Immediate cause of death: Cong. syphilis — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: not reported

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John R. Birmingham M.D.
Address JHH Date signed 2-23-45

VS 150

2542. X

626315 M. 92115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 626315

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 dys
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 W. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Pitts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 13, 1945

8. AGE: Years	Months	Days	If less than one day
		2	42 hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ervin Pitts
13. Birthplace N. C

MOTHER
14. Maiden Name Lillie Mae Dickens
15. Birthplace Phila

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) ~~Burial~~ cremation, ~~removal~~ (b) Date thereof 2-23-45 at 9 A. M.
(month) (day) (year)
(c) ~~Cemetery~~ crematory Baltimore City Hospitals
Location 4940 Eastern Ave (Records)

18 (a) Funeral director
(b) Address

19 (a) FEB 27 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15, 1945 at 11.45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13, 1945 to Feb. 15 1945, and that I last saw him alive on Feb. 15 1945.

	Duration
Immediate cause of death Congenital Atelectasis	42 hrs.
Due to	
Due to Delivered by Cesarean Section because of Placenta Previa	
Other Conditions Prematurity 34 mos.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. B. Perry, Jr. M. D.
M. D.
Address Balto City Hosp. Date signed 2/16/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6-66316

AB-92064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 104B

6-66316 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 809 Whatcoat St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Layton- Baby Boy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11-1945

8. AGE: Years	Months	Days	If less than one day
		9	hr. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Thatcher
13. Birthplace ?

MOTHER 14. Maiden Name Vivian Layton
15. Birthplace Pa.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) [redacted] (Burial, cremation, or removal) (b) Date thereof 2-23-45 at 9 A. M.
(month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave (Records

18 (a) Funeral director
(b) Address

19 FEB 27 1945 (Date rec'd by registrar) Huntington Williams M.D. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20- 1945, at 4AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-11- 1945, to 2-20- 1945 and that I last saw h 1m alive on 2-20- 1945.

Immediate cause of death	Duration
Basilar Meningitis & Strep	
Due to Sigus Thrombosis of Lateral & cavernous	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clifton D Gavan Jr M.D.
Address 13CH Date signed 2/23/45

VS 150

626317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 626317

94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1453 N. Carey St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town .....
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1453 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Thomas T. Ross.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julia Ross

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 69 | Months | Days | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Postman

11. Industry or business

FATHER
12. Name Alexander Ross
13. Birthplace Eastern Shore Md

MOTHER
14. Maiden Name Mary C. West
15. Birthplace Eastern Shore Md

16 (a) Informant Julia Ross (wife)
(b) Address 1453 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1-45 (month) (day) (year)
(c) Cemetery or crematory Mt Lion Cemetery
Location

18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey St

19 (a) FEB 27 1945 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25/45 19 at 11:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 19 45 to Feb 25 19 45 and that I last saw him alive on 2/25/45 19

Immediate cause of death Coronary Occlusion — Duration Hrs.

Due to Arter. Sclerosis — yrs.

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. C. Hamilton M.D.
Address 1631 Mount Ave Date signed 2/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626318

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92B

626318 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1516 E Madison
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 E Madison Av
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Brown

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race col'd | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 59 | Months | Days | If less than one day hr. min. 59

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Joshua Brown
13. Birthplace Va

MOTHER
14. Maiden Name Amanda Louis
15. Birthplace Middlesex Co, Va

16 (a) Informant Edward Fowler
(b) Address 1516 E Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-45 (month) (day) (year)
(c) Cemetery or crematory Mt Zion Cem
Location Baltimore Co. Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 Jeffersons St Huntingtown Hillcrest, Md.

19 (a) (Date received by registrar) FEB 27 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1945, at 1 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1945, to Feb 24 1945, and that I last saw h[illegible] alive on Feb 24 1945.

Immediate cause of death: Apoplexy — Duration 2 hrs.
Due to: Mitral Insufficiency
Due to: Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Edward Fowler M. D.
Address 1612 Monument St Date signed 2/26/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X O

626319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

626319 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1622 Latrobe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 Latrobe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathaniel Whiting

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 218-07-8368

4. Sex: M
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Alice Whiting
6 (c) If alive, give age 49 years
7. Birth date of deceased (mo., day, yr.) February 16, 1900
8. AGE: Years 45 | Months | Days 8 | If less than one day ... hr. ... min.
9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business —

FATHER
12. Name Jessee Whiting
13. Birthplace Va.

MOTHER
14. Maiden Name Estelle Burnell
15. Birthplace Va.

16 (a) Informant Alice Whiting
(b) Address 1622 Latrobe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 2 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn A. A. Co. Md.
18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 Jefferson Ste
19 (a) (Date rec'd by Registrar) FEB 27 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 1945 at 2:00 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from February 6 1945 to Feb. 26 1945
and that I last saw h alive on Feb. 25 1945.

	Duration
Immediate cause of death: Lobar pneumonia	2 Wks.
Due to: Hypertension	?
Due to: Aortic Regurgitation	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. Wallis Shemwell M. D.
Address 201 N. Carey St. Date signed 2/26/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

G26320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G26320 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 837 Leadenhall
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 837 Leadenhall (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Hall

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1888
8. AGE: Years 56 54 | Months 7 | Days 14 13 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Saloon
11. Industry or business

FATHER
12. Name Samuel Hall
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Hall
15. Birthplace Md

16 (a) Informant George Lewis
(b) Address 837 Leadenhall St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/45 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Balto City
18 (a) Funeral director Isaiah L. Brown
(b) Address 108 W Montgomery St
19 (a) (Date received by registrar) FEB 27 1945 Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23 1945, at 11:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1945, to 2/23 1945, and that I last saw him alive on 2/23 1945.

Immediate cause of death Uremia — Duration
Endocarditis — Duration
Due to Myocarditis — Duration
Due to — Duration
Other Conditions — Duration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 2/26/45

X

G26321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G26321 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Joseph Eisler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Not Known

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Not Known (Town, county, and state)
10. Usual Occupation Not Known
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Police Dept
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnell St

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto (Funeral Director or Person acting as such)

19 (a) FEB 27 1945 (Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26 1945, at 5 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Enquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V Disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature G.P. Schumacher M.D. (Medical Examiner)
Date signed 2/26/45

G26322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1311

Registered No. G26322

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2325 McCulloh St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2325 McCulloh (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret E. Tyler

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Leon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1896

8. AGE: Years 48 | Months 6 | Days 22 | If less than one day hr. min.

9. Birthplace Portsmouth Virginia (Town, county, and state)

10. Usual Occupation Retired School Teacher

11. Industry or business

FATHER
12. Name Robert Harper
13. Birthplace Va.

MOTHER
14. Maiden Name Octavia Jordan
15. Birthplace Va.

16 (a) Informant Octavia Harper
(b) Address 2325 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 27/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location

18 (a) Funeral director Mrs. Zorah Baysmore
(b) Address 1129 N. Hearlins St.

19 (a) FEB 27 1945 (Date received by Registrar) (b) Huntington Witness, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1945, at 11 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to Feb 23 1945, and that I last saw h[illegible] alive on Feb 23 1945.

Immediate cause of death: Chronic Nephritis (Uremia) — Duration: 9 mos.
Due to
Due to
Other Conditions: Arterio-Sclerosis & Hypertension also Acute Bronchitis — Duration: 9 mos.
(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph E. Young M. D.
Address 1424 E Monument St Date signed 2/26/45

G266323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

✓ G266323 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every question should be answered. Physicians: please write the correct age in especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1709 E. Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lydia S. Diggs

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ernest
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 17 1891

8. AGE: Years 54 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Back River Md. (Town, county, and state)
10. Usual Occupation Janitress
11. Industry or business

FATHER
12. Name Basil Browne
13. Birthplace Md.

MOTHER
14. Maiden Name Olivia Griffin
15. Birthplace Md.

16 (a) Informant Ernest Diggs
(b) Address 1709 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 28/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus M. Park
Location Arbutus, Md.

18 (a) Funeral director Mrs. Robert A. Elwell Dft.
(b) Address 1299 N. Caroline St.

19 (a) FEB 27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24-45 19 , at 5:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1944 to Feb 24 1945 and that I last saw h-r alive on 2-24-45 19

Immediate cause of death: Hypertension Cardio-Renal Disease — Duration: 2 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marion Adams, M. D.
Address 312 E 23rd Date signed 2-24-45

VS 150

G66324

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G66324 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 938 N. Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 938 N. Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daisey Brown Ellis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife JOSEPH

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-16-1889

8. AGE: Years 55 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace VA.
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name Wm. Robinson
13. Birthplace VA.

MOTHER
14. Maiden Name SARAH
15. Birthplace VA.

16 (a) Informant JOSEPH ELLIS
(b) Address 938 GILMOR STREET

17 (a) Burial (b) Date thereof 3-1-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A.A. County Md.

18 (a) Funeral director Williams & Jackson
(b) Address 916 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26 1945 30 at 12 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D.
Medical Examiner.
Date signed 2/26/45

VS 151 FEB 27 1945

93D

G26325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1005

G26325 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1803 Linden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Meiser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, ~~married~~, widowed, or ~~divorced~~: Widow

6 (b) Name of ~~husband~~ or wife: Charles Meiser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11 - 1853

8. AGE: Years 92 | Months | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Wm Pabs.
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Harry F. Meiser
(b) Address 4302 Old York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 25-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director John A Horan
(b) Address 4361 Greenmount Ave

19 (a) 2-7-1945 (Date rec'd by Registrar) (b) Huntington for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1945 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-20-1945 to Feb-24-1945 and that I last saw her alive on Feb-24-1945

Immediate cause of death: Cardiac insufficiency — | Duration
Due to: General arterio sclerosis
Due to:
Other Conditions: Thrombo-phlebitis of left leg —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Herman Seidel M. D.
Address 2404 Eutaw Pl. Date signed 2/26/45

VS 150

95 C

AB-90833 626326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

626326 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2645 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Addie L. Eaton

3 (b) If veteran, name war

3 (c) Social Security Account No. A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married-Sep.

6 (b) Name of husband or wife Charles E Eaton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25- 1888

8. AGE: Years	Months	Days	If less than one day
56	6		hr. min.

9. Birthplace Md. Harford Co Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Sentz (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Bowen (D)
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/1/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pleasant Hill Cem. ~~Mt. Pleasant Cem.~~
Location Owings Mills, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 27 1945 (b)
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1945 at 5.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25 1944, to 2-25- 1945, and that I last saw h~~er~~ alive on 2-25- 1945.

	Duration
Immediate cause of death: Pulmonary tuberculosis bilateral	2 yrs.
Due to:	
Due to:	
Other Conditions: Diabetes mellitus (Include pregnancy within 3 months of death)	6 yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto City Hosp. Date signed 2/26/45

Huntington Williams M.E

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

626327 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 312 E. North Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d/f
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 312 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Hackney

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Ernest

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17 1887

8. AGE: Years 57 | Months 5 | Days 8 | If less than one day hr. min.

9. Birthplace Canada
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name John Swift

13. Birthplace

MOTHER 14. Maiden Name Mary McDevett

15. Birthplace

16 (a) Informant Estale Hackney

(b) Address 312 E. North Ave.

17 (a) Burial (b) Date thereof 2/28/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory H. Rexecner

Location Belair Rd.

18 (a) Funeral director M. W. E. Dyer's Sons

(b) Address Lombard & Fremont Sts.

19 (a) FEB 27 1945 (b)
(Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1945, at 12:20 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 2/24 - 1945 to Feb 25 1945 and that I last saw him alive on 2-24 1945

Immediate cause of death	Duration
Hypertensive cardio	
Due to Vascular disease	
Hyper Tranquility + Arteriosclerosis	5 yrs +
Due to	

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify as part of place)
(e) Means of injury

23. Signature H. Henry Fellows M.D.

Address 5217 York Rd Date signed 2/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

1

G26328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G26328

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4805 Richard Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4805 Richard Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie (Kunigunda) Gaegler.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widow

6 (b) Name of husband or wife William A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 15-1871

8. AGE: Years	Months	Days	If less than one day
74		10	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Christopher Kack
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara ? ?
15. Birthplace Germany

16 (a) Informant Mrs. Elizabeth Gaegler
(b) Address 4805 Richard Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) FEB 27 1945 (b) Registrar
(Date rec'd by Registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1945, to Feb 25 1945, and that I last saw her alive on Feb 24 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	3 days
Due to Arteriosclerosis	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A Lee Thacher M. D.
Address 4116 Northern Parkway Date signed 2/26/45

X

G26323 TINDER G26323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No.

PLEASE WRITE LEGIBLY. Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2500 Allen Av.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Allen Av
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Finder

3 (b) If veteran, name war: W. W. #1
3 (c) Social Security Account No.: no.

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Ethel T. Finder
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 1- 1894
8. AGE: Years 50 | Months 5 | Days 24 | If less than one day hr. min.
9. Birthplace Rhea Georgia (Town, county, and state)
10. Usual Occupation administration asst.
11. Industry or business U. S. Government

FATHER
12. Name unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name annie woodles
15. Birthplace unknown

16 (a) Informant Mrs Ethel T. Finder
(b) Address 2500 Allen av
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/45 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Baltimore
18 (a) Funeral director J. Fleck
(b) Address 5305 Harford Ave.
19 (a) Date received by Local Registrar FEB 27 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1945, at 5P M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1944, to Feb. 25 1945, and that I last saw him alive on Feb. 25 1945

Immediate cause of death	Duration
Broncho Pneumonia	3 d.
Due to Metastatic Carcinoma	
metastasis to	
Due to Intestinal = to lung to brain	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Feb. 15 44
Major findings of operation: growth in sigmoid colon
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(c) Means of injury
23. Signature Esa Stevens M. D.
Address 2878 Harford Av Date signed 2/26/45

G26330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G26330

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 Elgin Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Edward V. Chartrand

3 (b) If veteran, name war	3 (c) Social Security Account No.
1st World	488-09-4398

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Vivian C. Chartrand
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1898

8. AGE: Years	Months	Days	If less than one day
46	5	6	..... hr. ..... min.

9. Birthplace St. Louis, Mo.
(Town, county, and state)
10. Usual Occupation Sect. & Treas.
11. Industry or business Allied Aviation

FATHER
12. Name -- Edward J. Chartrand
13. Birthplace -- St. Louis Mo.

MOTHER
14. Maiden Name -- Anna ?
15. Birthplace -- St. Louis Mo.

16 (a) Informant Mr. Robert E. Chartrand
(b) Address 3308 Elgin Ave.

17 (a) Removal (b) Date thereof 2/27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory --
Location St. Louis, Mo.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 27 1945 (Date received by Registrar) (b) Huntington Williams, Jr. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26 1945, at 4:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy - Inquest and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Walter J. Lubanski M.D.
Medical Examiner.
Date signed 2/26/45

G26331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G26331

Every item of information should be carefully supplied. Write the cause of death clearly and legibly. Underlining with RED INK. Every correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 300 S. Franklintown Rd

(c) Hospital or Institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 4

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 300 S. Franklintown Rd (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Bernard J. Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17-1874

8. AGE: Years	Months	Days	If less than one day
70 71	8	8	hr. min.

9. Birthplace Baltimore (Town, county and state)

10. Usual Occupation Retired Street Cleaner

11. Industry or business Balto City S S. Dept

FATHER 12. Name Jacob Baker

13. Birthplace Baltimore

MOTHER 14. Maiden Name Cathrine Brady

15. Birthplace Washington D.C

16 (a) Informant Mrs Dunhart

(b) Address 326 Franklintown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 28-45 (month) (day) (year)

(c) Cemetery or ——— St Peters Cemtery

Location Balto, Md

18 (a) Funeral director Milton Schilling

(b) Address 3914 S. Hanover St

19 (a) FEB 7 1945 (Date received by Registrar) (b) Registrar for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25th 1945 at 4:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945, to Feb 25 1945, and that I last saw h[illegible] alive on Feb 24 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 3 days

Due to Hypertension Cardiovascular Disease — Duration ? yrs

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(c) Means of injury —

23. Signature Harry Glassman M. D.

Address 753 W. Lafayette St Date signed Feb 27 45

G26332

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. G26332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be complete and correct as directed on other side. Give usual name of deceased person, if any, instead of "Baby" or "Stillborn." Fill in all items if possible. Where information is not known, so state. Be sure the age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~2010~~ 1120 N. Broadway (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MARY B McCAFFERTY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or ~~wife~~ John J. McCafferty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1882

8. AGE: Years 62 yrs. | Months 2 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank Jindra
13. Birthplace Czech.

MOTHER
14. Maiden Name Unknown
15. Birthplace Czech.

16 (a) Informant Husband
(b) Address ~~2010~~ N. Broadway

17 (a) Burial ~~1020~~ (Burial, cremation, or removal) (b) Date thereof 3/1/45 (month) (day) (year)

(c) Cemetery or ~~cremation~~ Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director C. E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (b)
(Date received by Local Registrar) FEB 27 1945 Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26 1945 at 3:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22 1945 to 2-26 1945 and that I last saw her alive on 2-25 1945

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertensive C.V.D.

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Bonamente M. D.
Address Univ Hosp Date signed 2-26-45

X

26333 BALTIMORE CITY HEALTH DEPARTMENT 5 9B Registered No. 26333

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 116 E CLEMENT ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 E CLEMENT ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY H. THUMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEM | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife. JOS B THUMAN

6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) FEB. 13 - 1868

8. AGE: Years 77 | Months 0 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace BALTIMORE. MD.
(Town, county, and state)

10. Usual Occupation HOUSE WORK.

11. Industry or business AT HOME

FATHER 12. Name AUGUST B HANEKE

13. Birthplace GERMANY

MOTHER 14. Maiden Name AUGUSTA ALBRECHT

15. Birthplace BERMANY

16 (a) Informant MR JOS B THUMAN

(b) Address 116 E CLEMENT ST

17 (a) BURIAL (b) Date thereof 2-28-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER

Location BALTO MD

18 (a) Funeral director Bernard C Hale

(b) Address 121 E West St

19 (a) FEB 27 1945
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 25 1945 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1940 to 2 25 19 45 and that I last saw h alive on 19

Immediate cause of death: Multiple Formative Duration 5 yrs
Due to Thyroidectomy and Hysterectomy 40 yrs
Due to Old Injuries

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Edward Norris M.D.
Address 107 Eastwood Rd Date signed 2-27-45

X

PHYSICIANS: PLEASE FURNISH, WHEN OBTAINABLE, THE INFORMATION REQUIRED BELOW. Every question should be carefully supplied. Please write the causes of death clearly and legibly. correct age is especially important. Physicians: please write the ca

G26334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G26334 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Lochearn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6605 Liberty Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernhardt Frey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Clara E. Frey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16 1872

8. AGE: Years	Months	Days	If less than one day
72	6	10	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

MOTHER / FATHER
12. Name Unknown
13. Birthplace Germany
MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs William L. Brooks
(b) Address 6415 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 1 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry N. Womack
(b) Address 4204 Ridgewood Ave

19 (a) (Signature of registrar) (b) Huntington Williamsport

FEB 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1941 to Feb 26 1945 and that I last saw h alive on Feb 25 1945.

Immediate cause of death Carcinoma of Sigmoid — Duration 4 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Feb 1941
Major findings of operation: Carcinoma of Sigmoid & Rectum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Smith M. D.
Address 4309 Liberty Hgts Date signed Feb 27

G66335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G66335 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 S. Franklintown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry F Seibert,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1871.

8. AGE: Years 73 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace Catonsville Md.
(Town, county and state)

10. Usual Occupation Retired Laborer

11. Industry or business

FATHER
12. Name Adolph Seibert
13. Birthplace Switzerland

MOTHER
14. Maiden Name Anna Burkhart
15. Birthplace Switzerland

16 (a) Informant Mrs. Katherine Vogt.
(b) Address 2623 Frederick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March, 1-45. (month) (day) (year)

(c) Cemetery or crematory Salem Cemetery
Location Catonsville Md.

18 (a) Funeral director Charles J. Schriver
(b) Address 505 N. Monroe St.

19 (a) FEB 27 1945 (Date rec'd by Registrar) (b) Huntington Hills (Registrar), Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 1945, at 9:15 A M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 20/4

(a) Date of injury February 24 1945 M.
(b) Where did injury occur? In front of 303 S. Franklintown Rd
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No

Means of injury Fall

23. Signature Robert L. Fretton M.D.
Medical Examiner.

Date signed 2-26-45

626336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

626336 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 118d
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4506 PENHURST AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** LANG, JOHN E. (John E. Lang)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	WIDOWED

6 (b) Name of husband or wife Mary V. Lang

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 5, 1862

8. AGE: Years	Months	Days	If less than one day
82	6	20	hr. min.

9. Birthplace BALT-O Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired Clerk

11. Industry or business

FATHER
12. Name Charles Lang
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Caroline Muhley
15. Birthplace BALTO, Md.

16 (a) Informant Mrs. Reuben C. Kinsley
(b) Address 4506 Penhurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 28, 1945 (month) (day) (year)
(c) Cemetery or crematory St. Paul's Cemetery
Location Druid Hill Park, Baltimore, Md.

18 (a) Funeral director Miller Lamonaco
(b) Address 4510 Liberty Heights Ave.

19 (a) FEB 27 1945 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25 1945, at 4.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-30 1944 to 2-25 1945, and that I last saw him alive on 2-25 1945

Immediate cause of death Terminal Broncho pneumonia — Duration 2-3d.

Due to Fracture-neck of femur L.T. — Duration 6 mos.

Due to

Other Conditions Hypostatic pneumonia, Decubitus ulcers

(Include pregnancy within 3 months of death)

Date of operation 10-14-44

Major findings of operation: Comminuted fracture neck of femur - L.T. Extensive hypostatic pneumonia, coronary sclerosis

Was autopsy held from findings of medical examiner?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence October 30, 1944 M
(c) Where did injury occur? Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? No
(Specify type of place)
(e) Means of injury Slipped off curb

23. Signature Charles Lewis Hall M. D.
Address C.H.H. Date signed 2-25-45

V8 189 (OVER) For C.H.B. Dr. Neely, by Howard J. Mackesie, M.D.

G26337 SICKER Sicker G26337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city, or town limits, write RURAL and give town)
(d) Street No. 333 Holcroft St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony J. Socken (Siekierski)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-10-6557

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Victoria

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15, 1910

8. AGE: Years	Months	Days	If less than one day
35	1	9	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business

FATHER
12. Name Anthony Siekierski
13. Birthplace Poland

MOTHER
14. Maiden Name Sophia Kosiba
15. Birthplace Poland

16 (a) Informant Wife
(b) Address 333 Holcroft St.

17 (a) Burial (b) Date thereof 2/28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location Anne Arundel County

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

19 (a) FEB 27 1945 (b) [illegible] Registrar
(Date rec'd by registrar)

Hunting for William M.B.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24- 1945 at 6.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Congestive Cardiac Failure

Due to Electrocution

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-24- at 16/2 6.10 P M.
(b) Where did injury occur Schmitz Bakery, Camp & Fayette
(c) Did injury occur at home, on farm, industrial place, in public place Industrial While at work? Yes.
(d) Means of injury While repairing electric fixtures

23. Signature Howard J. Mc Sherry M.D.
Medical Examiner.

Date signed 2-25-45

VS 151

G26338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83D

G26338

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 906. N. Washington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 906. N. Washington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RENATO. CENCI

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 196-01-7009.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Augusta Cenci

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 27. 1885

8. AGE: Years 49. Months 11-2 Days 24-27 If less than one day hr. min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual Occupation: Coal MINER

11. Industry or business

FATHER
12. Name: Eugene Cenci
13. Birthplace: Italy

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Italy

16 (a) Informant: Augusta Cenci
(b) Address: 906 E. N. Washington St

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 2-28-45 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Road

18 (a) Funeral director: Rendell Heppel
(b) Address: 312 S. Highland Ave

19 (a) FEB 27 1945 (b) (Date rec'd by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1945 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1943 to Feb 23 1945 and that I last saw him alive on Feb 23 1945.

Immediate cause of death: Pneumo Coccus Streptococcus Pneumoniae — Duration: 5 yrs 1 day

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Milton L. Solomon M. D.

Address 129 S Bway Date signed 2/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87D

Registered No. G26339

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th. St
(c) Hospital or institution:
Home for Incurables 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th. St.
(If rural give location)
(e) Citizen of foreign country? ~ (Yes or No)
If yes, name country ~

3 (a) **FULL NAME** Mrs Florence Merryman Gaddess

3 (b) If veteran, name war	3 (c) Social Security Account No.
~	~

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widow

6 (b) Name of husband or wife Mr Edwin Gaddess
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/29/1881

8. AGE: Years	Months	Days	If less than one day
64		27	3 hr. 20 min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Reading
11. Industry or business

FATHER
12. Name Mr. Wesley M. Merryman
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Miss Carrie Sides Brown
15. Birthplace Baltimore

16 (a) Informant E Hartman
(b) Address Home for Incurables

17 (a) Burial (b) Date thereof Feby 28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Road

18 (a) Funeral director John W Mitchell Sons
(b) Address 1600 Eutaw Place

19 (a) FEB 28 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26th 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1st 1938, to Feb. 26 1945, and that I last saw her alive on Feb. 24th 1945.

Immediate cause of death	Duration
Bronchial Pneumonia	4 weeks
Due to	
Due to	
Other Conditions Multiple Sclerosis Arthritis Deformans	18 years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Conrad G.P. M.D.
Address 11 E. Chase St. Baltimore 2 Date signed 2/28/45

107

G26340

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

G26340 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ----------
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. Weens Creek (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Robert M. Papa

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Catherine Papa

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 17, 1878

8. AGE: Years 66 | Months 8 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Fabia Papa
13. Birthplace Italy

MOTHER
14. Maiden Name Marie
15. Birthplace Italy

16 (a) Informant Mrs. Edward Holland
(b) Address 16 Park ave. New York, N.Y.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/27/45 (month) (day) (year)
(c) Cemetery or crematory New York City
Location New York

18 (a) Funeral director Chas. J. Evans & Son, Inc.
(b) 2/27/1945 118 W. Mt. Royal Ave
Huntington Williams Registrar

19 (a) ____ (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26 1945 at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/22 1945 to 2/26 1945 and that I last saw him alive on 2/26 1945

Immediate cause of death	Duration
Coronary Occlusion	6 days
Due to Infarction	7 days
Due to Acute Pericarditis	7 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation ____

Major findings of operation: ____

of autopsy: Coronal Infarction Acute Pericarditis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury ____

23. Signature Richard C. Hayden M. D.
Address Bon Secours Date signed 2/26/45

VS 150

X

G26541 G26541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1250 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ Hosp. 27
(d) Length of stay in hospital or inst. ([illegible] days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County * *
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 Rosebank Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country * *

3 (a) **FULL NAME** Patricia Anne Garrigan

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife * *
6 (c) If alive, give age * years

7. Birth date of deceased (mo., day, yr.) Nov. 7 - 1927

8. AGE: Years 17 | Months 3 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation School Girl

11. Industry or business

FATHER
12. Name P. Francis Carrigan
13. Birthplace Baltimore

MOTHER
14. Maiden Name Ann H. Pinning
15. Birthplace Balti-more

16 (a) Informant Irvin Pinning
(b) Address 1416 North Gate Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick

18 (a) Funeral director Chas F Evans-Son
(b) Address 618 W Mt. Royal Ave

19 (a) 8 27 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25 1945 at 11 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15 1945 to 2-25 1945, and that I last saw h[illegible] alive on 2-25 1945

Immediate cause of death: Acute yellow atrophy of liver — Duration
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature R B Marment III
Address Univ. Hosp. Date signed 2/26/45 M. D.

Huntington Williams, M.D.

VS 150

X

Please write the causes of death clearly and legibly. Physicians: please write in ink. Every item of information should be carefully supplied; correct age is especially important.

G26342 HIGGINS G26342

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1102

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 173 N. Pearl St. Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Patrick James Higgins

If U.S. Veteran specify WAR

(a) Residence: No. 173 N Pearl St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
W	W	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6. DATE OF BIRTH (month, day, year) Dec 5-1863

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
81	-	2	23	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Md

FATHER

13. NAME Patrick Higgins

14. BIRTHPLACE (city or town) (State or country) ?

MOTHER

15. MAIDEN NAME ?

16. BIRTHPLACE (city or town) (State or country) ?

17. INFORMANT Mrs Higgins

(Address) 401 N Edmondson Ave

18. BURIAL, CREMATION, OR REMOVAL Cremation

Place Laurel Md Date Feb 27 1945

19. UNDERTAKER John T. Gable & Sons

(Address) 518 Light St

20. FILED FEB 27 1945 Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 2/27/45

22. I HEREBY CERTIFY, That I attended deceased from Dec 27 1944 to 2/27/45

I last saw h[illegible] alive on Dec 21 1945. Death is said to have occurred on the date stated above, at 8:30 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Myocarditis	Unknown
Other contributory causes of importance: Senility	Unknown

Was an operation performed? ... Date of ...

For what disease or injury? ...

What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ...

If so, specify ...

(Signed) Wm T Gorsuch M.D.

(Address) 401 N Edmondson

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

93a

G26343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G26343

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1335 North Gilmore
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Hyles

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex m | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. Sep.

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895 1946

8. AGE: Years (49) 49 | Months | Days | If less than one day hr. min.

9. Birthplace Montgomery Co. Md.
(Town, county, and state)

10. Usual Occupation Grader

11. Industry or business

FATHER
12. Name Wm Hyles
13. Birthplace Montgomery Co. Md

MOTHER
14. Maiden Name Iona Palmer Bigus
15. Birthplace Montgomery Co. Md

16 (a) Informant Robert Hyles
(b) Address 1335 Gilmore St

17 (a) Burial (b) Date thereof 2/28/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Montgomery Co. Md.
Location Md

18 (a) Funeral director Geo. D. Kelson
(b) Address 1303 Presstman St

19 (a) FEB 27 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 45, at 3:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry on and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 2/26/45

VS 151

626344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

626344 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1008 Eager St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 Eager St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Morgan Barney

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	M

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/29/1923

8. AGE: Years	Months	Days	If less than one day
21	8	26	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Lula Morgan
13. Birthplace N. C.

MOTHER
14. Maiden Name Imelove Clarke
15. Birthplace N. C.

16 (a) Informant Joseph Barney
(b) Address 1008 Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/45 (Month) (day) (year)
(c) Cemetery or crematory Arlington
Location Md.

18 (a) Funeral director Geo. B. Kelso
(b) Address 1203 Piedmont St.

19 (a) FEB 27 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. (Address)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25, 1945, at 2 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-22-44 19 , to 2-25 1945, and that I last saw h[illegible] alive on 2-24-1945

Immediate cause of death C. Nephritis — Duration 6 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice Blum, M. D.
Address 312 E 23rd St. Date signed 2-26-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

0 X

G26345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

Registered No. G26345

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL, and give town.)
(d) Street No. 626 W. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Newman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Fem.

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years 37 | Months | Days | If less than one day hr. min.

9. Birthplace Oconee Co. S.C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name W. Mack
13. Birthplace S.C.

MOTHER
14. Maiden Name Capie
15. Birthplace S.C.

16 (a) Informant Robert Neuman
(b) Address 626 W. Lanvale St

17 (a) Burial (b) Date thereof 3/3/45
(Burial, cremation, or removal) (Month) (day) (Year)
(c) Cemetery or crematory Gilmor
Location Md

18 (a) Funeral director Wm. H. Kelson
(b) Address 1303 Pressman St

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26, 1945, at 8:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20 1945, to 2/26 1945, and that I last saw her alive on 2/26 1945.

Immediate cause of death Malignant Hypertension — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature James D. Carr
Address Provident Hospital Date signed 2/28/45 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Information should be complete and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G26534G
AB-92299

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH √14

G26534G
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 E. Fort Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Hawks

3 (b) If veteran, name war	3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Della
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5- 1880

8. AGE: Years	Months	Days	If less than one day
64	3	20	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jacob Hawks
13. Birthplace Va.

MOTHER
14. Maiden Name Zelphia Jones
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Removal (b) Date thereof Feb. 27 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Fries Va.

18 (a) Funeral director Martin J. Conners
(b) Address 402 Fourth St. Huntington Williams, W.V.

FEB 27 1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25- 1945, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24 1945 to 2-25 1945, and that I last saw h im alive on 2-25- 1945.

Immediate cause of death tuberculous meningitis ? — Duration ?
Due to
Due to
Other Conditions hypertensive cardio vascular disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: report deferred

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Piercy Jr. M. D.
Address City Hosp Date signed 2-26-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 C

G26547 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4026 Evans Chapel Rd.
(c) Hospital or institution:
13-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4026 Evans Chapel Rd.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel M. Miller

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah Delila Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1866

8. AGE: Years	Months	Days	If less than one day
78	10	11	hr. min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)
10. Usual Occupation Bricklayer
11. Industry or business Retired - 15 years

FATHER
12. Name Samuel B. Miller
13. Birthplace Maryland

MOTHER
14. Maiden Name Kesiah B. Myer
15. Birthplace Maryland

16 (a) Informant Mrs. Ethel Taylor
(b) Address 4026 Evans Chapel Rd.

17 (a) Burial (b) Date thereof Feb. 28, '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co., Md.
18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road
19 (a) (b) Registrar.
(Date rec'd by registrar)

VS 150 FEB 27 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1945, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1944 to Feb. 25 1945.
and that I last saw him alive on Feb. 23, 1945.

Immediate cause of death	Duration
Myocarditis	2 mo.
Due to Advanced arterio-sclerosis	?
Due to	
Other Conditions Arthritis deformans 4 yrs.	

(Include pregnancy within 3 months of death)
Date of operation ---
Major findings of operation: ---
of autopsy: ---- a.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ------
(b) Date of occurrence --------- at M
(c) Where did injury occur? ----
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? --- While at work? ---
(Specify type of place)
(e) Means of injury ------
23. Signature Hattie L. Tublett M. D.
Address 2220 Garrison Date signed Feb. 27/45

X

626348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 946

626348 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1743 Milton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRY CHARLES MILLER

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 218-12-8812A

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1877

8. AGE: Years	Months	Days	If less than one day
68	0	20	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Fireman, ret. 8 yrs

11. Industry or business: Balto. City Fire Dep't.

FATHER
12. Name: Henry Miller
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Margaret Zink
15. Birthplace: Unknown

16 (a) Informant: Mrs. Margaret Miller
(b) Address: 1743 W. Milton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-45 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Date received by registrar) FEB 27 1945 (b) Registered number

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26, 1945, at 12:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Hugh B. McNally M.D. Medical Examiner.

Date signed 4/26/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

626349 Registered No. 46B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): Adm. 1/30/45
(e) Length of stay in Baltimore (yrs., mos., or days): Since 1/30/45-2:00 P.M.

2. USUAL RESIDENCE OF DECEASED:
(a) State: N. Y. (b) County:
(c) City or town: New York City (If outside city or town limits, write RURAL and give town)
(d) Street No.: 324 W. 19th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country:

3 (a) **FULL NAME** [redacted], Camille E. Hertsens

3 (b) If veteran, name war: -

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9/27/1887

8. AGE: Years: 57 | Months: 4 | Days: 29 | If less than one day: hr. min.

9. Birthplace: ? Belgium (Town, county, and state)

10. Usual Occupation: Butcher

11. Industry or business: Merchant Marine

FATHER
12. Name: Leopold ~~Hertsens~~ Hertsens
13. Birthplace: Belgium

MOTHER
14. Maiden Name: Collette ?
15. Birthplace: Belgium

16 (a) Informant: Records, U.S.Marine Hosp.
(b) Address: Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 1 1945 (month) (day) (year)
(c) Cemetery or crematory: Rose-dale - Lindenwald
Location: Linden, New Jersey

18 (a) Funeral director: Henry Sander & Sons Inc
(b) Address: North east Broadway.

19 (a) FEB 27 1945 (Date rec'd by registrar) (b) Registrar: Huntington Williams M.D.

VS 160

(over)

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: Feb. 25, 1945, at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/30 1945 to 2/25 1945 and that I last saw him alive on Feb. 25, 1945.

Immediate cause of death: Carcinoma of the stomach with extensive generalized metastases — Duration: Unk.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: None done

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: No
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Benjamin F. Jones M.D.
Address: Baltimore, Md. Date signed 2/25/45

X

G26350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G26350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 900 N. Belnord ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 N. Belnord ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary T. Mikszyn

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John Mikszyn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1870

8. AGE: Years	Months	Days	If less than one day
75	1	24	hr. min.

9. Birthplace Bohemia (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Michael Rochac
13. Birthplace Bohemia

MOTHER
14. Maiden Name Anna Krejci
15. Birthplace Bohemia

16 (a) Informant Frank Mikszyn
(b) Address 4114 N. Duncan St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balt. Md.

18 (a) Funeral director Frank Gorski Son
(b) Address 900 N. Chester St.

2 27 1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1945, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17 1939 to Feb. 24 1945, and that I last saw h[illegible] alive on Feb. 24 1945

Immediate cause of death	Duration
Acute Cardiac Dilatation	6 hrs
Due to Hypertensive Heart Disease with Auricular Fibrillation	6 yrs
Due to	
Other Conditions Arterio-sclerosis with Hypertension	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene N. Joska M. D.
Address 845 N. Patterson Pk. Date signed 2/27/45

Huntington Williams, M.D.

26351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G26351

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Spencer P.O. Box 422
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Mace

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Unknown

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1912

8. AGE: Years 32 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Spencer W. Va.
(Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business Castle Rubber Co.

FATHER
12. Name George Mace
13. Birthplace W. Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Carl M. McKown
(b) Address Spencer W. Va.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/1/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Spencer
Location Spencer W. Va.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

FEB 28 1945
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26- 1945, at 11 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-26- at 5:50 P. M.
(b) Where did injury occur? Esso Filling Station
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Jumping or fall, fracture of skull, head

23. Signature Howard J. Mullens M.D.
Medical Examiner.
Date signed 2-27-45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 626352

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 E. Monument St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 Penna ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Goldberg, Samuel Solomon.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Gladys

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25. 1901

8. AGE: Years 43 | Months 7 | Days 2 | If less than one day hr. min.

9. Birthplace: England (Town, county, and state)

10. Usual Occupation: Merchant

11. Industry or business

FATHER
12. Name: Emanuel Goldberg
13. Birthplace: Poland

MOTHER
14. Maiden Name: Miriam Weinberg
15. Birthplace: Poland

16 (a) Informant: Mrs. Gladys Goldberg
(b) Address: 1400 Penna ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/45 (month) (day) (year)

(c) Cemetery or crematory: Hebrew Rosedale
Location: Hamilton ave

18 (a) Funeral director: Sol Levinson & Bros.
(b) Address: 1124-26 W. North ave

19 FEB 28 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27 1945 at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-27 1945 to 2-27 1945, and that I last saw h.a.m. alive on 2-27 1945.

Immediate cause of death: Intercranial Hemorrhage — Duration

Due to: Hypertensive Cardiovascular disease

Due to:

Other Conditions: Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Jerome R. Harlan M. D.
Address: Sinai Hospital Date signed 2/28/45

93D

626353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 626353

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington st
(c) Hospital or institution: Aged Womens' Aged Mens' Home
(d) Length of stay in ~~hospital or~~ inst. (yrs., ~~mos., or days~~) 5 years
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma A. Siegk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 12th 1861

8. AGE: Years 83 | Months 4 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Manchester Md.
(Town, county, and state)

10. Usual Occupation Inmate

11. Industry or business Home for Aged

FATHER
12. Name John Sigk
13. Birthplace Germany

MOTHER
14. Maiden Name Adeline Stober
15. Birthplace Germany

16 (a) Informant Records Aged Women's Aged Mens' Homes
(b) Address 1400 W. Lexington st.

17 (a) Burial (b) Date thereof 3/2/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery or ~~crematory~~ St. Thomas
Location Garrison Forrest

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (Date rec'd by registrar) FEB 28 1945 Registrar for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26th 1945, at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18/1939, to 2/26/1945, and that I last saw her alive on 2/25/45 19...

Immediate cause of death	Duration
Myocarditis, chronic	1 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm B. Jason M. D.

Address 11 E. Chase St., City Date signed 2/27/45

VS 150

G26354 — 058 ON — G26354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

PLEASE WRITE PLAINLY, WITH (UN)FADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2129 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Osborn Raymond Marshall.
3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 214-12-9216

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Mrs Laura Marshall.
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) May 20, 1890

8. AGE: Years	Months	Days	If less than one day
54	9	6	hr. min.

9. Birthplace Indiana (Town, county, and state)
10. Usual Occupation Ships Carpenter
11. Industry or business Fairfield Ships Yard

FATHER
12. Name ? Marshall
13. Birthplace Indiana

MOTHER
14. Maiden Name Rachel Osborn
15. Birthplace Indiana

16 (a) Informant Laura B.E. Marshall
(b) Address 2129 Md. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 (a) FEB 28 1945 (Date received by Registrar) (b) Huntington Wilson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27/45 19..., at 1.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/22 1945, to 2/27 1945, and that I last saw h[illegible] alive on 2/26 1945.

Immediate cause of death	Duration
Cardio-respiratory failure.	
Due to Lobar pneumonia - all 3 lobes, R. lung	5 days
Due to Pneumococcal meningitis	5 days
Other Conditions apparently contributing heart failure	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Fred Hawkins, Jr. M. D.
Address Union Memorial H. Date signed 2/27/45

VS 150

26355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1040

Registered No. 26355

Please write the causes of death clearly and legibly. Physicians: please write the causes as especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 Fleet Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Fleet Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Valiant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 24th 1944

8. AGE: Years | Months: 6 | Days: 2 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew Valiant
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Olga Losovski
15. Birthplace Russia

16 (a) Informant Olga Valiant
(b) Address 1610 Fleet St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/6/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Oak Hill
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 129 St. Paul St.

19 (a) FEB 28 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 1945, at 5 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Upper Respiratory Infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mulder M.D. Medical Examiner.
Date signed February 27, 1945.

6266356 AB-11898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

6266356 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs- 1 mos-1day
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 780 Mc Henry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Webster

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Chas. H. Webster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4-1877

8. AGE: Years	Months	Days	If less than one day
67	6	22	hr. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Webster
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Armanda Rice
15. Birthplace Baltimore, Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/1/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St

19 (a) FEB 28 1945 (Date rec'd by registrar) Hunting for Willi (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26- 1945, at 3.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-25- 1936 to 2-26- 1945 and that I last saw her alive on 2-26- 1945

Immediate cause of death	Duration
Myocardial insufficiency	Mos?
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions Chronic old myocardial infarct Chronic P.L.D. (Include pregnancy within 3 months of death)	?

Date of operation
Major findings of operation:
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospitals Date signed 2-27-45

626557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

626557 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Old Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3026 Pinewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jerome P. McDowell

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband~~ or wife Elva M. Van Allen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17th 1868

8. AGE: Years	Months	Days	If less than one day
76	10	10	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or busines R. R. Mechanic - Pa. R.R.

FATHER
12. Name John B. McDowell
13. Birthplace Unknown

MOTHER
14. Maiden Name Sarah Haigel
15. Birthplace "

16 (a) Informant Florence McDowell
(b) Address 5706 Harford Rd

17 (a) Burial (Burial, ~~cremation, removal~~) (b) Date thereof 3/1/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ St. Marys
Location Hampden

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) FEB 28 1945 (Date rec'd by registrar) (b) Registrar's No.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27th 1945, at 6a. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1942 to Feb 27 1945, and that I last saw him alive on Feb 23 1945.

Immediate cause of death	Duration
Bronchial Asthma	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. H. Patterman M. D.
Address 2324 Reisterstown Rd Date signed 2/27/45

G26358 | BALTIMORE CITY HEALTH DEPARTMENT | G26358

CERTIFICATE OF DEATH

83a | Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3 1872

8. AGE: Years	Months	Days	If less than one day
72	9	22	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Unemployed.

11. Industry or business

FATHER
12. Name Samuel H. Walker
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Sarah J. Rider
15. Birthplace Baltimore Md.

16 (a) Informant Owen Walker
(b) Address 134 Newburg Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore Md.

18 (a) Funeral director Loring Byers.
(b) Address 5005 Park Heights Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS FEB 28 1945 Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25 1945 at 11.00 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh R. McCalls M.D. Medical Examiner
Date signed 2/27/45

G26353 ✓ G26353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7 Stratford Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 Stratford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Joseph Carter) Joseph Melvin Cone Carter

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen L. Carter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 5th 1890

8. AGE: Years	Months	Days	If less than one day
54	2	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Real Estate Operator
11. Industry or business Self

FATHER
12. Name John Francis Carter
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Florence C. Webb
15. Birthplace Virginia

16 (a) Informant Mrs. Louise C. Broderson
(b) Address 7 Stratford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 3- 1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore County, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

19 (a) (Date rec'd by registrar) (b) Hunter Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27 1945 at 9:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 2-27-45

VS 151

G26360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G26360

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2831 Northern Pkwy.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2831 Northern Pkwy.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DORA E. BUNTING

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles Henry Bunting

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1874

8. AGE: Years 71 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace Harford Co. (Jarrettsville)
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jacob Emrich
13. Birthplace Germany

MOTHER
14. Maiden Name Mary E. (Unknown)
15. Birthplace Germany

16 (a) Informant Mr. George H. Bunting
(b) Address 2831 Northern Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25, 1945 at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1945 to Feb 25 1945 and that I last saw h alive on Feb 24 1945

Immediate cause of death Failing Compensation
Chronic Valvular Disease

Duration ?

Due to

Due to

Other Conditions Failing Compensation
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

10 Days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. T. Lyman

Address 316 Hanford Rd Date signed M D 2/26/45

G26361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30B

G26361 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 330 S. George St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RUTH E. FRANKS

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife William F. Franks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1900

8. AGE: Years	Months	Days	If less than one day
44	8	3	hr. min.

9. Birthplace Westminster, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Clarence L. Scheiblein
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Hilda E. Franklin
15. Birthplace Westminster, Md.

16 (a) Informant Mr. William F. Franks
(b) Address 330 S. George St., York, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26, 1945, at 9 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1945 to Feb 26 1945, and that I last saw h[illegible] alive on Feb 26 1945

Immediate cause of death — Duration

Broncho pneumonia — 10 days

Due to

Due to

Other Conditions Meningo encephalitis Luetica - since Nov 1944
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Tom Truedom M. D.

Address 1031 St. Paul St Date signed 2/27/45
Baltimore

Huntington Pittsburgh

107

G26362 ✓ BALTIMORE CITY HEALTH DEPARTMENT ✓ G26362

CERTIFICATE OF DEATH 108

Registered No. 19392

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton + Wilkenson
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8c

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town St. Denis - Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1724 River Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Thelma Domeier ✓

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Henry F. Domeier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1906

8. AGE: Years 38 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Ellsworth Vain
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Emma ?
15. Birthplace Balto., Md

16 (a) Informant Mrs. Margaret Mayer
(b) Address Rolling Rd., Relay, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.,

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27- 1945, at 4 5/6 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22 1945 to 2-27- 1945, and that I last saw her alive on 2-27- 1945

Immediate cause of death Bilateral Lobar Pneumonia — Duration

Due to Complicating Rheumatic Cardio-Vascular Disease

Due to

Other Conditions Cardiac Decompensation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles J. Carr Jr M. D.
Address St. Agnes Hosp. Date signed 2/27/45

626363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 626363

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 903 W. 38th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 W. 38th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES P. DORSEY

3 (b) If veteran, name war --

3 (c) Social Security Account No. 717 - 07 - 7221

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Marion L. Dorsey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1875

8. AGE: Years	Months	Days	If less than one day
69	6	12	hr. min.

9. Birthplace Laurel, Md. (Town, county, and state)
10. Usual Occupation Retired Car Inspector
11. Industry or business Penna. R. R.

FATHER
12. Name John H. Dorsey
13. Birthplace Md.

MOTHER
14. Maiden Name Clarinda Reed
15. Birthplace Md.

16 (a) Informant Mrs. Marion L. Dorsey
(b) Address 903 W. 38th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 28 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26, 1945, at 4:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1945 to Feb 26 1945 and that I last saw him alive on Jan 24 1945

Immediate cause of death	Duration
Bronchopneumonia	
Due to Carcinomatosis	
Due to Carcinoma of Stomach	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin H. Flassman M. D.
Address 4037 Fed Hill Date signed 2/27/45

VS 150

G26364 BALTIMORE CITY HEALTH DEPARTMENT G26364
CERTIFICATE OF DEATH 830a
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3707 Belle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3707 Belle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JULIA FREDERICK FAULKNER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Italius Tertuis Faulkner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1869

8. AGE: Years 75 | Months 3 | Days 4 | If less than one day hr. min.

9. Birthplace Lynchburg, Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Faulkner
13. Birthplace Va.

MOTHER
14. Maiden Name Rose Frederick
15. Birthplace Va.

16 (a) Informant Mrs. Arthur Pfeiffer, Jr.
(b) Address 3707 Belle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.
FEB 28 1945

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26, 1945, at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 16 1944 to Feb 26 1945; that I last saw her alive on Feb 26 1945

Immediate cause of death: Cerebral apoplexy. — Duration:
Due to: Generalized arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Kreeble M. D.
Address 7314 - W. Hub Rd Date signed 2/27/45

Planting for Mrs. Will

66865 V 66865

BALTIMORE CITY HEALTH DEPARTMENT 97 Registered No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 424 E. 25th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 424 E. 25th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE WOLFE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Lawrence Wolfe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1852

8. AGE: Years	Months	Days	If less than one day
92	3	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry C. Ryan
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Eleanor Peas
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Blanche Ireton
(b) Address 424 E. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/45 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) FEB 28 1945 (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26, 1945 at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20th. 44 to 2/26 19 45.
and that I last saw her alive on 2/26 19 45.

Immediate cause of death	Duration
Arteriosclerosis	about 5 yr
Due to ----- ------	
Due to	
Other Conditions ----------	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lew Margetruth M.D.
Address 401 E. 25th. St. Date signed 2/28/45.

Treating for Williams M.D.

X

G26366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Registered No. G26366

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 117 N. Streeper St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 117 N. Streeper St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Margaret Kaiser
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 27-1866
8. AGE: Years 78 Months 1 Days 28 If less than one day hr. min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home
FATHER 12. Name Nicholas Kaiser
13. Birthplace Germany
MOTHER 14. Maiden Name Catherine Klipschmidt
15. Birthplace Germany
16 (a) Informant Louise Epstein
(b) Address 117 N. Streeper St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Wendell St
18 (a) Funeral director John E. Miller Inc
(b) Address 2425 E. Oliver St
(c) Huntington Williams Robinson
FEB (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1945, at 2:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945 to Feb 25 1945 and that I last saw her alive on Feb 25 1945

Immediate cause of death Bronchio-pneumonia
chronic myocarditis
Due to mitral insufficiency - Duration 2-4-45
arteriosclerosis - 1-2-45
Due to
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis H. Krumeich M. D.
Address 722 W. Lemmon Date signed 2/26/45

VS 150

626307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D (626307) Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 Myrtle Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 Myrtle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Pratt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895, May

8. AGE: Years 49 | Months 9 | Days | If less than one day hr. min

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name ?
13. Birthplace Md.

MOTHER
14. Maiden Name Lucille
15. Birthplace Md.

16 (a) Informant Mr. Emory Pratt
(b) Address 1302 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Director or person acting as such) (b) Registrar

FEB 28 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26, 1945 at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3 — 1945, to 2-26 — 1945, and that I last saw her alive on 2-19 — 1945.

Immediate cause of death	Duration
Chronic myocarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C.R. Campbell M. D.
Address 718 Dolphin St. Date signed 2-27-45

X

266368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166 266368 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 560 Oxford Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE MILBOURNE (WELBORNE)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1919

8. AGE: Years	Months	Days	If less than one day
25	5		hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Welborne
13. Birthplace N. C.

MOTHER
14. Maiden Name Madison
15. Birthplace Va.

16 (a) Informant James B. Welborne
(b) Address 560 Oxford St.

17 (a) Burial (b) Date thereof 3-2-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Gordensville
Location Va.

18 (a) Funeral director C. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) FEB 28 1945 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 1945 at 2:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gun shot wound of abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-24-45 at 12 Midnight M.
(b) Where did injury occur? In front of 1044 Penn Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Shot during altercation

23. Signature Howard J. Mendeis M.D.
Medical Examiner.
Date signed 2-25-45

X

626369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. 626369

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 528 Johannsen St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 528 Johannsen St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Wheeler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name John Wheeler
13. Birthplace Md.

MOTHER 14. Maiden Name Eliza
15. Birthplace Md.

16 (a) Informant Ethel Wheeler
(b) Address 528 Johannsen St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-45 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Charles L. Law
(b) Address 802 Madison Ave.

19 (a) (Date received by registrar) FEB 28 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25, 1945, at 8 00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13 1945 to 2-25 1945 and that I last saw h[illegible] alive on 2-21 1945

Immediate cause of death	Duration
Pulmonary Tuberculosis	6 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. Atwell Jones M. D.
Address 600 Dolphin St. Date signed 2-27-45

626370 469637. BALTIMORE CITY HEALTH DEPARTMENT 626370
CERTIFICATE OF DEATH 157E Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3141 Elmora Ave. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Harriett Rangley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-18-45

8. AGE: Years	Months	Days	If less than one day
		9	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Harry Rangley
13. Birthplace Md.

MOTHER
14. Maiden Name Minnie Kay Watt
15. Birthplace N.C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/45 (month) (day) (year)
(c) Cemetery or crematory Solomons M.E. Cemetery
Location Solomons Island, Md.

18 (a) Funeral director Howard N. Bright Jr.
(b) Address 4914 Belair Road.

19 (a) (Signature of local registrar) Huntington Williams M.D. Registrar

FEB 28 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb-27- 1945, at 10.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-26 1945 to Feb-27 1945, and that I last saw h.m alive on Feb 27 1945.

Immediate cause of death	Duration
Pleural effusion right	
Due to Atelectasis, left lung	5 days
Due to Pneumonia RUL?	
Other Conditions? Coronary heart disease	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy: Not reported

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature John R. Bunningham
Address JHH Date signed 2-28-45

110B

626371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

626371 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12 S. Pine St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 S. Pine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bertha Stanley
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Fem
5. Color or race Col
6 (a) Single, married, widowed, or divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1901

8. AGE: Years 43 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Cook.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Charlotte
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Doris Stanley Jones
(b) Address 12 S. Pine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 28 1945 Huntington Hall Baltimore Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23 1945 at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/22 1945 to 2/23 1945 and that I last saw her alive on 2/23 1945

Immediate cause of death Duration

Pyelonephritis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Welcome M.D.
Address 1131 Hadwin Rd. Date signed 2/26/45

G66372 BALTIMORE CITY HEALTH DEPARTMENT 94a G66372 Registered No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4029 FALLS Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13'
(e) Length of stay in Baltimore (yrs., mos., or days) 40YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4029 FALLS Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY SUSSHON

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: TILLIE
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1885
8. AGE: Years 57 Months Days If less than one day hr. min.
9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation TAILOR
11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant TILLIE SUSSHON - WIFE
(b) Address 4029 FALLS RD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-28-45 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location O'DONNEL ST

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS-110 FEB 28 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27-45 19 , at ✓ A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/26 1945 to 2/27 1945. and that I last saw him alive on 2/26 1945.

	Duration
Immediate cause of death: Ventricular Fibrillation	
Due to: Coronary Thrombosis	2 days
Due to: Coronary Artery Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward G. Hassman M. D.
Address 4037 Fools Rd Date signed 2/27/45

X

G26573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G26573

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where date is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1429 Hanover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 Hanover St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ignacy (Ignac) Redzyk

3 (b) If veteran, name war: 1st World War

3 (c) Social Security Account No. No

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1886

8. AGE: Years 59 | Months | Days 26 | If less than one day hr. min.

9. Birthplace Meshenica Russia (Town, county, and state)

10. Usual Occupation Furniture Finisher

11. Industry or business Furniture Mfg.

FATHER
12. Name Thomas Redzyk
13. Birthplace Russia

MOTHER
14. Maiden Name Rozalia Nackowska
15. Birthplace Russia

16 (a) Informant Thomas Redzyk
(b) Address 1429 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 2 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto Md

18 (a) Funeral director J. Bernard Evans
(b) Address 1460 St Paul St

19 (a) FEB 28 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27, 1945; at 8:50 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/26/1944 to 2/27/1945 and that I last saw him alive on 2/26/1945.

Immediate cause of death	Duration
Pulmonary edema	2 mos.
Due to Myocardial failure	
Due to Arterio sclerotic heart disease.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. B. Taylor M.D.
Address 1226 Hanover St. Date signed 2/28/45 M. D.

VS 150

26374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No. 26374

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Gibson Island
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice F. Ely

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife late Wm Ely

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1865

8. AGE: Years 80 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Iowa (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Ferguson
13. Birthplace Scotland

MOTHER
14. Maiden Name Jeanette
15. Birthplace Scotland

16 (a) Informant Mortimer S. North
(b) Address Gibson Island

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2-28-45 (month) (day) (year)
(c) Cemetery or crematory ~~Fort Lincoln~~ Loudon Park Cem
Location

18 (a) Funeral director Harry A Wiltze
(b) Address 101 E Lanvale St

19 (a) (b) Registrar

FEB 28 1945 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26 1945, at 9½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24 1945, to 2-26 1945, and that I last saw her alive on 2-26 1945.

Immediate cause of death Ruptured abdominal aortic aneurysm.
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy: Rupt of abd. aorta

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Univ Hosp Date signed 2/26/45

X

G66375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. G66375

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2518 Jefferson Street
(c) Hospital or institution: 1/2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2518 Jefferson Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie Sanders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or ~~wife~~ Edward Sanders
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1887

8. AGE: Years	Months	Days	If less than one day
57 yrs.	9	28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John J. Schreiber
13. Birthplace Baltimore

MOTHER
14. Maiden Name Lena Schrader
15. Birthplace Baltimore

16 (a) Informant Husband
(b) Address 2518 Jefferson Street

17 (a) Burial (b) Date thereof 2/28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Baltimore
Location Baltimore, Md.

18 (a) Funeral director C.E.Schimunek
(b) Address 2601 E. Madison Street

19 (a) FEB 28 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1945 at 11:50 pm

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10, 1944 to Feb. 25 1945.
and that I last saw h~~er~~ alive on Feb. 25, 1945.

Immediate cause of death Carcinoma of Rectum and Metastatic Carcinoma of Liver — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation March 1944.

Major findings of operation: Carcinoma of Rectum Sigmoid & Metastases

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irving C. Wolfe

Address 1331 E. North Ave. Date signed 2-27-45.

VS 150

626376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

626376 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 K. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Moss.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-22-95

8. AGE: Years	Months	Days	If less than one day
49	9	3	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Worker.

11. Industry or business

FATHER 12. Name Frank Moss

13. Birthplace Va

MOTHER 14. Maiden Name Puzzie Macklin

15. Birthplace Va

16 (a) Informant Friends.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 3-2-45 (month) (day) (year)

(c) Cemetery or crematory Diamond Grove Cem

Location Emporia Virginia

18 (a) Funeral director Gilliam & Jackson

(b) Address 916 Penbe ave

19 (a) FEB 28 1945 (Date received by Registrar)

Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1945 at 12.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 24 1945 to Feb 25 1945 and that I last saw him alive on Feb. 25 1945.

Immediate cause of death Respiratory failure — Duration

Due to Pulmonary tuberculosis advanced

Due to with cavitation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Dison

Address Johns Hopkins Hospital 2/26/45

X

626577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

626577 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 E. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lula Lipps

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John H

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-16-89

8. AGE: Years 56 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace W. Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Dawson
13. Birthplace W. Va.

MOTHER 14. Maiden Name Sarah Booker
15. Birthplace W Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof Feb 28 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Bridgeport W Va
Location Bridgeport W Va

18 (a) Funeral director Ellwick Funeral Home
(b) Address 208 S 8 Clarksburg W Va

19 (a) FEB 28 1945 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27 1945 at 7:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1945 to Feb 27 1945 and that I last saw her alive on Feb 27 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Chronic myelogenous leukemia	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Cenecor M. D.
Address Johns Hopkins Date signed 2-27-45

G26578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

89a

G26578 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item o. information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 314 S Robinson
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md' (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 314 S. Robinson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marsha Karol

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/24/44

8. AGE: Years | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Steve Karol

13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Dorothy Marsh

15. Birthplace Bath

16 (a) Informant Steve Karol

(b) Address 314 S Robinson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/45 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem Catonsville

Location

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2005-9 Eden

19 (a) FEB 28 1945 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1945, at 10:04 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1944 to Feb 26 1945 and that I last saw h.e.r alive on Feb 26 1945

Immediate cause of death — Duration

Resp. Failure

Due to Atelectasis - Aspiration Pneumonia plus

Due to

Other Conditions Otitis Media

(Include pregnancy within 3 months of death)

Date of operation Tracheotomy 2/25

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Brown M. D.

Address Sinai Hosp Date signed 2/Feb/45

161a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

~~626579~~ 1942 Registered No. 626379

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 S Decker Ave
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 S. Decker Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard ~~Grisner~~ Grisner

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-09-6259

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Marie Grisner
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 2/13/1891

8. AGE: Years	Months	Days	If less than one day
54 51	-	14	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Nat Can Co

FATHER
12. Name John Grisner
13. Birthplace Balto

MOTHER
14. Maiden Name Annie Caulert
15. Birthplace Balto

16 (a) Informant John A Barnes
(b) Address 618 S Decker Ave

17 (a) Burial (b) Date thereof 3/3/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Morelands Park
Location Rural

18 (a) Funeral director Tellrock Funeral Home
(b) Address 2004-8 Orleans

19 (a) (Date rec'd by registrar) (b) Huntington Hill Registrar, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1945, at 4:55 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 2-27-45

G26380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G26380
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item on this certificate should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5241 Patrick Henry Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl (A) Heiss

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/27/45

8. AGE: Years | Months | Days: 0 | If less than one day: 11 hr. 50 min.

9. Birthplace Franklin Square Hospital (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Sonia Heiss
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Paul Heiss
15. Birthplace Baltimore, Md.

16 (a) Informant Mother
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-45. (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Philadelphia & Crowley Aves.

18 (a) Funeral director Jack Lenz Inc.
(b) Address 1439 E. Preston St.

19 (a) FEB 28 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1945, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27 1945 to 2/28 1945, and that I last saw her alive on Feb 28 1945.

Immediate cause of death: Respiratory Failure — Duration:
Due to: Prematurity (7 Months)
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers M. D.
Address Franklin Sq. Hosp. Date signed 3/2/45.

G26381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G26381 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3701 Ellamont St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3701 Ellamont St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aaron Caplan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Hannah Caplan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years 86 Months Days If less than one day hr. min.

9. Birthplace Poth
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Meyer Caplan

13. Birthplace Poth.

MOTHER 14. Maiden Name Ella —

15. Birthplace Poth

16 (a) Informant Oscar Caplan (Son)

(b) Address 3225 Dickeyville Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-45 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Balto. St

19 (a) FEB 28 1945 (Date rec'd by registrar) (b) [illegible] for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-28-45 19 , at 10 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 1/10 1940 to 2/28 1945, and that I last saw h alive on 2/27 1945.

Immediate cause of death Coma Acute Pneumonia — Duration 3 days

Due to Chronic Myocarditis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Frankel M. D.
Address 1111 Eutaw Pl. Date signed 2/28/45

VS 130

G26382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G26382 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1110 N Gilmor St

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1110 N. Gilmor St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lena Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem	Colrd	Widow

6 (b) Name of husband or wife Bradley Bailey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Abey Smith

13. Birthplace Va

MOTHER 14. Maiden Name Agnes Mad Hurt

15. Birthplace Va

16 (a) Informant

(b) Address 1110 N Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/45 (month) (day) (year)

(c) Cemetery or crematory Acomac Co, Va Location Va

18 (a) Funeral director Geo. H. Kyson

(b) Address 1303 Preastman St

19 (a) FEB 28 1945 (Date received by registrar) Huntington Williams M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1945 at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1945 to Feb 26 1945. and that I last saw h alive on Feb 26 1945

Immediate cause of death Acute Pulmonary Edema

Due to Not determined

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles T Wood M. D.

Address 861 Dunbar Date signed 2-27-45

626383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47D

626383 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1411 Patapsco St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1411 Patapsco St
(If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia J. Oliver

3 (b) If veteran, name war –

3 (c) Social Security Account No. 214-03-2705

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles Oliver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23-1889

8. AGE: Years 55 | Months 3 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Collar Setter

11. Industry or business Shirt Manufacturer

FATHER 12. Name Anton Ullmann

13. Birthplace Austria

MOTHER 14. Maiden Name Pauline Kragel

15. Birthplace Austria

16 (a) Informant Charles Oliver

(b) Address 1411 Patapsco St.

17 (a) Burial (b) Date thereof March 1-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location Pitchin Highway G.G. Co.

18 (a) Funeral director Elizabeth Starke Sons.

(b) Address 115 S. West St.

19 (a) FEB 23 1945 (b)
(Date rec'd by registrar) (Registrar)

Hunter & Co Milwaukee, Wis

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 1945, at 4 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1944 to Feb 26 1945 and that I last saw h[illegible] alive on Feb 25 1945.

Immediate cause of death Carcinoma Lung.

Duration

Due to

Due to

Other Conditions Pulmonary Oedema.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature John G. Schemmel M. D.

Address 1337 S. Charles St. Date signed 2/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Use ditto marks only when correct. Where exact age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G26384

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G26384 Registered No. 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Baltimore Md
(a) Baltimore City, Maryland
(b) Street address 1425 Argyle Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1425 Argyle Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Middleton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Col.	

6 (b) Name of husband or wife Walter Middleton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
62	—	—	hr. min.

9. Birthplace Potomac. City Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Ella M. Dent
(b) Address 1425 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary,
Location A. A. Co Md

18 (a) Funeral director Gaith Alexander
(b) Address 937 N. Mount St

FEB 28 1945

15 (b) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to Feb 27 1945 and that I last saw h alive on 2/26 1945

Immediate cause of death Cardio-Renal

Due to

Due to.

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 2 Mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. J. Hatcher

Address 1215 Park Ave Date signed 2/27/45 M. D.

G26385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G26385 Registered No.

CWK #84289

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 4 - 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Dauses

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28-1869

8. AGE: Years 75 | Months 8 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name George Hartman
13. Birthplace Germany

MOTHER
14. Maiden Name Cathlene
15. Birthplace Germany

16 (a) Informant Records, Balto. City Hosp.
(b) Address 4940 Eastern Ave.

17 (a) Burial [illegible] (b) Date thereof 2/20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location [illegible]

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) [illegible] (b)
(Date received) (Registrar) Registrar

FEB 28 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18- 1945, at 5:20PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12, 1943, to Feb. 18, 1945, and that I last saw him alive on Feb. 18, 1945.

Immediate cause of death: Broncho pneumonia — Duration: 3 days

Due to

Due to

Other Conditions: Senile dementia, Hypertension, Hydrocele
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City of town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospitals Date signed 2-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26386 — BALTIMORE CITY HEALTH DEPARTMENT — G26386

CERTIFICATE OF DEATH V 20a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3013 Westfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Elizabeth Colen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-9-10

8. AGE: Years	Months	Days	If less than one day
34	5	19	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Beautician

11. Industry or business

FATHER
12. Name Major Burgoyne Cannon
13. Birthplace Maryland

MOTHER
14. Maiden Name Lucy Foxwell
15. Birthplace Maryland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md

18 (a) Funeral director John A. Mitchell & Sons
(b) Address 1900 Eutaw Place,

19 (a) Filed FEB 28 1945 (b) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1945 at 2 07 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 20 1945 to Feb. 28 1945 and that I last saw her alive on Feb. 28 1945

Immediate cause of death Respiratory Failure — Duration ? 2 days
due to Brain abscess and meningitis — 18 days.
Due to Salmonella suipestifer septicemia in hospitalization — 6 weeks
Due to early malaria complete (metastatic abscess due to salmonella) — 1 yr.
Other Conditions CNS Syphilis - Tabes Dorsalis.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham Colen
Address Johns Hopkins Hospital Date signed M. 2-28-45 D.

80a

G26387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46D

G26387 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID F. WILHELM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ida M. Wilhelm

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name ADAM WILHELM
13. Birthplace MD.

MOTHER
14. Maiden Name MARY EBERGH
15. Birthplace MD.

16 (a) Informant Mrs. D. F. Wilhelm
(b) Address Cockeysville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Forrestville Cem.
Location Balto. Co., Md.

18 (a) Funeral director Landon M. Bunting
(b) Address Sparks, Md.

19 (a) MAR 1 1945 (Registrar) (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23 1945, at 6:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20 1945 to 2-28 1945, and that I last saw h im alive on 2-23 1945.

Immediate cause of death Intestinal Obstruction — Duration 2 wks

Due to Ca of Rectum

Due to

Other Conditions Cecostomy
(Include pregnancy within 3 months of death)

Date of operation ~~Mar.~~ 2-22-45

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Carl Ebeling III M.D.

Address Mon. Hosp. Date signed 2-28-45

No. 150

G26388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G26388 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2102 Pennsylvania Ave D.O.A.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Blanchard

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Gloster Co. Va
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business ?

FATHER
12. Name ?
13. Birthplace Va.

MOTHER
14. Maiden Name ?
15. Birthplace Va.

16 (a) Informant Robert Blanchard
(b) Address 2102 Penna Ave

17 (a) Burial (b) Date thereof 3/1/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. D. Kelbaugh
(b) Address 1303 Priestman St

19 MAR 1 - 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26 1945, at 5:20 P M

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature B. K. Rubinski M.D.
Medical Examiner.
Date signed 2/26/45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G26389
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1240 James St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Lithuania

3 (a) FULL NAME John Litkauskas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1886

8. AGE: Years	Months	Days	If less than one day
58	8	7	hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name John Litkauskas
13. Birthplace Lithuania

MOTHER
14. Maiden Name Rose Panza
15. Birthplace Lithuania

16 (a) Informant Frances Litkauskas
(b) Address 1240 James St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 1 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Beloit Rd

18 (a) Funeral director Joseph Kasunakas Jr.
(b) Address 662 Washington Blvd

19 (Date received by registrar) MAR 1 - 1945 Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 1945 at 2 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-23 1945 to 2-26 1945 and that I last saw h(im) alive on 2-26 1945.

Immediate cause of death	Duration
Intestinal Obstruction	
Due to	
Due to	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. J. Brady M. D.
Address Md Gen Hosp. Date signed 2-26-45

122B

626390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1612

626390 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 Myrtle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 Myrtle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lettie Viola Allen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1945

8. AGE: Years	Months	Days	If less than one day
		8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Edward Allen
13. Birthplace S. C.

MOTHER
14. Maiden Name Charlain Wood
15. Birthplace S. C.

16 (a) Informant Mr. Edward Allen
(b) Address 211 Myrtle Ave.

17 (a) Burial (b) Date thereof 3-1-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (b) Huntington Williams, M.D.
(Date received by registrar) Registrar
MAR 1 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27, '45 19 , at 5P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 19 , 1945 , to Feb 27 1945 ,
and that I last saw h alive on 19 .

Immediate cause of death Pulmonary Atelectasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 95 [illegible] Date signed 3/28/45

6391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940 Registered No. G-26391

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 820 Park ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County None
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 Park Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Woolford Chunn (Mrs. Wm P. Chunn)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or ~~wife~~ Dr. Wm P Chunn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1867

8. AGE: Years	Months	Days	If less than one day
77	3		hr. min.

9. Birthplace Richmond Va (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business Home

FATHER
12. Name James Woolford
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Mabel C. Wilson
(b) Address 820 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) Mch 2/45
(c) Cemetery or crematory Green Mt.
Location Green Mt Booth Ave

18 (a) Funeral director John A Mitchell & Son
(b) Address 1700 Eutaw Place

19 MAR 1 - 1945 (Date rec'd by registrar) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1945, at 8.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to 2/27 1945.
and that I last saw h[illegible] alive on Feb 27 1945.

Immediate cause of death	Duration
Coronary Thrombosis	1 week
Due to Coronary Sclerosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature Frances W. Gluck, M.D.
Address 715 Park ave Date signed 3/1/45

VS 150

26392 — HEALTH DEPARTMENT—CITY OF BALTIMORE — 26392

CERTIFICATE OF DEATH

46D

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. The Crawford Retreat St., Ward) 1721 Dennison St.

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ....yrs....mos....ds. How long in U. S. If of foreign birth?....yrs....mos....ds.

2. FULL NAME Bertha Hoffman

If U.S. Veteran — specify WAR

(a) Residence: No. 5012 Eugene Ave St., Ward. Balto.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W.	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) April 10, 1872

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	10	17	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Head housekeeper

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Private estate

10. Date deceased last worked at this occupation (month and year) June 1938

11. Total time (years) spent in this occupation 40

12. BIRTHPLACE (city or town) (State or country) Germany

MOTHER FATHER

13. NAME Christian Hoffman

14. BIRTHPLACE (city or town) (State or country) Germany

15. MAIDEN NAME Johanna Gaull

16. BIRTHPLACE (city or town) (State or country) Germany

17. INFORMANT Mrs Lester C. McCormick Murray

(Address) 5012 Eugene Ave, Balto 4

18. BURIAL, CREMATION, OR REMOVAL

Place Loraine Cemetery Date Mch 2 1945

19. UNDERTAKER John Oursler Sons & Sons

(Address) 1900 Eutaw Place

20. FILED MAR 1 - 1945 Huberta for Williams, Registrar.

MAIL CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb 27, 1945

22. I HEREBY CERTIFY, That I attended deceased from August 19, 1942 to Feb 27, 1945

I last saw h.r alive on Feb 25, 1945 Death is said to have occurred on the date stated above, at 7:25 P.m. - Feb 27 45

The principal cause of death and related causes of importance were as follows:

Carcinoma of the Rectum & Generalized Metastases - Date of onset 1939?

Other contributory causes of importance:

None -

Was an operation performed? yes - Date of Feb 30, 1944

For what disease or injury? Adenocarcinoma of the Rectum

What test confirmed diagnosis? Biopsy Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ....Date of injury ....., 19....

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) James L. Crump M. D.

(Address) 18 W. Franklin -

X

66393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. G66393

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 Eastship Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ODIE LEE Channell

3 (b) If veteran, name war: None
3 (c) Social Security Account No. -

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ora A. Channell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1889

8. AGE: Years 55 | Months 4 | Days 12 | If less than one day: hr. min.

9. Birthplace West Virginia
(Town, county, and state)
10. Usual Occupation Stock Dept.
11. Industry or business Beth. Steel Corp.

FATHER
12. Name Elias E. Channell
13. Birthplace West Va.

MOTHER
14. Maiden Name Sarah R. Smith
15. Birthplace West Va.

16 (a) Informant Mrs. Ora Channell
(b) Address 24 Eastship Rd., Dundalk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/45 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem.
Location Glen Burnie, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 1 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28 1945, at 8:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/26 1945, to 2/28 1945, and that I last saw him alive on 2/28 1945.

Immediate cause of death Peripheral vascular collapse — Duration 12 hrs.

Due to Post operative — for intestinal obstruction — 4 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/27

Major findings of operation: Enteral hernia.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen A. Hoon M. D.
Address University Hosp. Date signed 2/28/45

X

626394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

75 B

626394 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St
(c) Hospital or institution: Md Univ.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 26

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Daniels
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice L Engle

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21, 1921

8. AGE: Years 24 | Months 0 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md (Town, County, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Reno Engle
13. Birthplace Md

MOTHER
14. Maiden Name Ethel Stumpf
15. Birthplace Md

16 (a) Informant Reno Engle
(b) Address Daniels Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-45 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City Md.

18 (a) Funeral director H. Hyattstown
(b) Address Ellicott City Md

19 (a) MAR 1 - 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27 1945, at 1 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1 1945 to 2-27 1945 and that I last saw her alive on 2-27 1945.

Immediate cause of death	Duration
Post operative Hemorrhage	
Due to Splenectomy	
Due to	
Other Conditions Thrombocytopenic purpura (Include pregnancy within 3 months of death)	

Date of operation 2-27-45
Major findings of operation: Splenomegaly
of autopsy: Abdominal Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P B Wagement III, M. D.
Address Univ Hosp. Date signed 3/17/45

Huntington Williams, M.D.

VS 150

395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 626395

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1634 Belter St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1634 Belt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael J. Garrity

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11. 1883

8. AGE: Years 61 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Patricke
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary A. McLynn
15. Birthplace Balto Md.

16 (a) Informant Mrs. Mary A. Garrity
(b) Address 1634 Belt St.

17 (a) Burial (b) Date thereof Mch. 4-1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Balto, Md

18 (a) Funeral director McLynn & Fleming
(b) Address 1426 Light St

APR 1 - 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1945; at 6-30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 26 1944 to Feb 25 1945 and that I last saw h m alive on Feb 25 1945

Immediate cause of death: Coronary Thrombosis — Duration 3 hrs.

Due to: Influenza — 6 days

Due to: Bronchitis — 3 mos.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1279 Fulton Ave Date signed 2/28/45

X

626396 626396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1780 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hobart L. Riggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25. 1934

8. AGE: Years: 10 yrs | Months: 9 | Days: 1 | If less than one day: hr. min.

9. Birthplace La Follette, Tenn (Town, county, and state)

10. Usual Occupation School Boy

11. Industry or business

FATHER
12. Name Joye Riggs
13. Birthplace Tenn

MOTHER
14. Maiden Name Lettie Richards
15. Birthplace Tenn

16 (a) Informant Joye Riggs
(b) Address La Follette, Tenn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 4. 1945 (month) (day) (year)
(c) Cemetery or crematory Davis Chapel
Location La Follette Tenn

18 (a) Funeral director Mr. Mrs. John W. Teufel & Son
(b) Address 801 W. Fayette St.

19 (a) (b) Huntington Williams, M.D.

MAR 1 1945
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26 1945 at 3:45 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest (Autopsy, Inspection or Inquiry) thereof and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxia

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/26/45 at about 2:30 P.M.
(b) Where did injury occur? 615 W. Lexington St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Gas escaping from heater

23. Signature H. Williams M.D. Medical Examiner.
Date signed 3/26/45

626397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

626397

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4119 Westview Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4119 Westview Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate Ellen Helwig Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John E. Lewis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1879.

8. AGE: Years 65 | Months 10 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Robert F. Holmes
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Kate Wiegner
15. Birthplace Baltimore, Md.

16 (a) Informant John E. Lewis
(b) Address 4119 Westview Rd.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof March 3/45. (month) (day) (year)
(c) Cemetery or crematory Lorraine Pk. Mausoleum
Location Woodlawn, Md.

18 (a) Funeral director Harry A. Nitzke
(b) Address 4103 Edmondson Ave.

MAR 1 - 1945 (Date rec'd by registrar) (b) Huntington for Nellie Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28/45. 19 at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1935 to Feb. 28 1945 and that I last saw h-e alive on Feb. 28 1945.

	Duration
Immediate cause of death Acute myocardial failure	1 hr.
Due to coronary arteriosclerosis; general arteriosclerosis &	2 mo. + 10 yr. +
Due to hypotension.	10 yr. +
Other Conditions Arteriosclerosis	10 yr. +

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robt. B. Wright M. D.

Address Medical Arts Bldg. Date signed 3/1/45

VS 150

94a

626398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

626398 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 237 S. Loudon Ave .
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 237 S. Loudon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Murr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1877

8. AGE: Years	Months	Days	If less than one day
67	11	13	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Robert Murr
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Thomas
15. Birthplace Germany

16 (a) Informant Mrs. Anna White
(b) Address 237 S. Loudon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 2/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. & Gay St.

18 (a) Funeral director Harry H. Wright
(b) Address 4101 Edmondson Ave.

19 (a) MAR 1 - 1945 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28/45. 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1930 to Feb-28 1945, and that I last saw her alive on Feb-27 1945.

Immediate cause of death Uremia Ulcer — Duration 25 yrs

Due to ?

Due to

Other Conditions 0

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation:

of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide 0
(b) Date of occurrence 0 at M
(c) Where did injury occur? 0
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. Lloyd Johnson M. D.
Address Catonsville. Md Date signed 3-1-45

VS 150

G66393 ✓ G66393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1535 W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 27 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1535 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Walter J. Via

3 (b) If veteran, name war .....

3 (c) Social Security Account No. 215 05 3251

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary M. (Elliott)
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 29, 1883.

8. AGE: Years	Months	Days	If less than one day
61	7 8	29	hr. ..... min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Baker
11. Industry or business Hot Doughnot Shop

FATHER
12. Name John W. Via
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Crenshaw
15. Birthplace Va.

16 (a) Informant Mrs. Mary M. Via
(b) Address 1535 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 2/45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave. & Longwood St.

18 (a) Funeral director Harry H. Duffie
(b) Address 4101 Edmondson Ave.

19 (a) MAR 1 - 1945 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1945 at 4^ M

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1944 to July 27 1945.
and that I last saw him alive on July 27 1945.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Nephritis & Hypertension	
Due to [illegible]	2 Days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Theo Kaadaney M.D.
M. D.
Address 1715 N Prath Date signed 7/1/45

VS 150

G26400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G26400 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 243 N Schroeder
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 243 N Schroeder (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Irene Craig

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1944

8. AGE: Years | Months: 10 | Days: 6 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Whitfield Craig
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Vera Woodson
15. Birthplace Baltimore Md

16 (a) Informant Vera Craig
(b) Address 243 N Schroeder

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 1, 19[illegible] (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 622 N Schroeder St

19 (a) MAR 1 1945 (Date rec'd by registrar) (b) Huntington B. Woodward, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1945 at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1945 to Feb 27 1945; and that I last saw h[illegible] alive on Feb 27 1945.

Immediate cause of death	Duration
Bronchopneumonia	3 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury

23. Signature W. H. Watts
Address 6154 Carlington Date signed 3/1/45

X

26401

BALTIMORE CITY HEALTH DEPARTMENT ✓ G26401

CERTIFICATE OF DEATH 83a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 Division St.
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 Robert St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Bates

3 (b) If veteran, name war

3 (c) ~~Social Security~~ Account No. None

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1897

8. AGE: Years 47 | Months 7 | Days 7 | If less than one day: hr. min.

9. Birthplace Lovingsville, Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Abraham Bates
13. Birthplace Lovingsville, Va.

MOTHER
14. Maiden Name Louisa Shelton
15. Birthplace Lovingsville, Va.

16 (a) Informant Martha Boone
(b) Address 512 Robert St.

17 (a) Burial (b) Date thereof March 1, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto. Co. Md.

18 (a) Funeral director Wm. Carl W. Holland
(b) Address 1631 Druid Hill Ave.

MAR 1 - 1945 Huntington Williams Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 1945, at 6 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/16 1945, to 2/26 1945, and that I last saw her alive on 2/26 1945.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James D. Carr, M. D.
Address Provident Hospital Date signed 2/26/45

X

6402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No. G-2640c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2044 WILKINS AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 S PACA ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ZULA V. HUFFMAN (HOFFMAN)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	MARRIED

6 (b) Name of husband or wife DAVID L. HUFFMAN
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) MARCH 16 1884

8. AGE: Years	Months	Days	If less than one day
60	11	12	hr. min.

9. Birthplace VIRGINIA.
(Town, county, and state)
10. Usual Occupation HOUSE WORK.
11. Industry or business AT HOME.

FATHER
12. Name EMOS SPRINKEL
13. Birthplace VA.

MOTHER
14. Maiden Name IDA FREY
15. Birthplace VA

16 (a) Informant DAVID L. HUFFMAN
(b) Address 512 S PACA ST.

17 (a) REMOVAL (b) Date thereof 3-2 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HARRISONBURG VA
Location "

18 (a) Funeral director Bernard C Hanks
(b) Address 121 E Mdt St

APR 1 - 1945 (a) (b) Huntington Williamsport
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 28 1945, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1945 to Feb 28 1945 and that I last saw h.. alive on Feb 24 1945

Immediate cause of death Cerebral Hemmorrhage. Hemiplegia -
Due to Cerebral Accident
Due to Hemmorrhage
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
1 wk
1 wk

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Paul Schofield
Address 230 annapolis Date signed 2/28/45 M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G26403 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 805 S. Hanover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 805 S. Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Allen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 50 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Perry Green

13. Birthplace Md.

MOTHER 14. Maiden Name Alice Allen

15. Birthplace Md.

16 (a) Informant Rose Green

(b) Address 805 S. Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Elroy C. Wilson

(b) Address 1000 Brantley Ave.

19 (a) ... (Date received by registrar) MAR 1 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26 1945 at 2:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1945 to 2/26 1945 and that I last saw h[illegible] alive on 2/25 1945

Immediate cause of death Pulmonary Obstruction
Duration 2 hrs

Due to Hepatic Enlargement
Duration 2 mo

Due to
Duration

Other Conditions
Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. N. Fletcher M.D.

Address 1 W Pr St Date signed 2/28/45

G26404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1472

G26404 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3022 Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Patsiris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Mabel Patsiris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2 1895

8. AGE: Years 49 | Months 9 | Days 25 | Less than one day hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Restaurant Owner

11. Industry or business

FATHER
12. Name Peter Patsiris
13. Birthplace Greece

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mabel Patsiris
(b) Address 3022 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-45 (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Wingston Mill Rd.

18 (a) Funeral director Saunders Funeral Home Inc.
(b) Address 440 S. North Ave.

19 (a) MAR 1 1945 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27 1945, at 2 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1944, to 2/27 1945, and that I last saw h[illegible] alive on 2/27 1945.

Immediate cause of death: Bronchogenic Carcinoma — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers
Address Franklin Sq. Hosp. Date signed 2/28/45

Huntington Hospital

626405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

626405 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 S. Durham
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 S. Durham St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Magdalena Durneika

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
About 84			hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Charles Durneika
13. Birthplace Lithuania

MOTHER
14. Maiden Name
15. Birthplace Lithuania

16 (a) Informant Victor Donnick
(b) Address 615 S. Durham

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto Md.

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern ave

19 (a) MAR 1 - 1945 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28 1945 at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/16 1945 to 2/28 1945 and that I last saw h[illegible] alive on 2/28 1945

Immediate cause of death	Duration
Mitral insufficiency	
Coronary thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Peter F. Neumann M. D.
Address 1076 E Eat Ave Date signed 3/1/45

VS 150

626406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

626406 Registered No. 838

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2220 Barclay St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Dorothy Trott (Dorothy Adele Trott)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/5/02

8. AGE: Years	Months	Days	If less than one day
42	2	23	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation Nurses aid.
11. Industry or business

FATHER 12. Name Samuel W. Trott
FATHER 13. Birthplace Balto Md.
MOTHER 14. Maiden Name Emma McCurry
MOTHER 15. Birthplace Balto Md.

16 (a) Informant Mrs. Henry R. Cook
(b) Address 2220 Barclay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.
18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street
19 (a) APR 1 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28 1945 at 9:35 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 1945 to 2/28 1945 and that I last saw her alive (2:AM) on 2/28 1945.

Immediate cause of death	Duration
Cardiorespiratory failure	
Due to Cerebrovascular accident	7 hrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Jos. Fred Hourigan, Jr. M. D.
Address Union Memorial Hosp. Date signed 2/28/45

VS 150

626407

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V63

626407
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 209 Harmisson St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 209 Harmisson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice P Richerson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Geo. Richerson
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2/16/1878

8. AGE: Years: 67 | Months: — | Days: 11 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Samuel Soper
13. Birthplace Md.

MOTHER
14. Maiden Name Alonda Jeffers
15. Birthplace Md.

16 (a) Informant Mrs. Ruth Hauk
(b) Address 209 Harmisson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 March 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director J. B. Wilkinson Son
(b) Address 857 W. Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 1 - 1945

Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26/1945, at 2.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944, to 2-26- 1945, and that I last saw h[illegible] alive on 2-26- 1945.

Immediate cause of death: Ethelcrania
Due to: Left Sided Pneumonia
Due to: —
Other Conditions: Pulmonary Oedema

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert D. Richerson M.D.
Address 2151 Wilkens Ave Date signed 2/26/45

L66108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓108

Registered No. 66408

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 101 N. WASHINGTON ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DOROTHY LEE GREGORY

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NONE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 28 1942

8. AGE: Years 2 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name HAROLD GREGORY
13. Birthplace MISSOURI

MOTHER
14. Maiden Name DOROTHY WILSON
15. Birthplace BALTO. MD.

16 (a) Informant DOROTHY GREGORY (MOTHER)
(b) Address 110 N. WASHINGTON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 2/45 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Geiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) MAR 1 1945 (Date received by Registrar) (b) Registrar

VS 151

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 27 1945, at 10:00 A M

21. I certify that I took charge of the remains described above, held an AUTOPSY thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Frasham M.D. Medical Examiner.
Date signed Feb. 28 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626409

BALTIMORE CITY HEALTH DEPARTMENT

626409

CERTIFICATE OF DEATH 94a

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5016 Erdman Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5016 Erdman Avenue
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME Dominick. (Gabriele) GILOTTE

3 (b) If veteran, name war .....

3 (c) Social Security Account No. 188-01-3102

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Sarafine Gilotte
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 4-1890

8. AGE: Years 54 ~~55~~ | Months 5 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Expenser

11. Industry or business Bethlehem Fairfield

MOTHER / FATHER
12. Name Frank Gilotte
13. Birthplace Italy

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Sarafine Gilotte
(b) Address 5016 Erdman Ave.

17 (a) Burial (b) Date thereof 3- -45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory .....
Location Scranton, Pa.

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd.

19 (a) MAR 1 - 1945 (b) .....
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1945 at 10 ~~P~~ A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 1 1945

VS 151

Entries must be typewritten or legibly written in ink. Physicians please write the cause of death clearly and legibly.

G26410 — BALTIMORE CITY HEALTH DEPARTMENT — G26410

CERTIFICATE OF DEATH 49a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Oakeland hrs.
(c) Hospital or institution West Balto. Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8d 14
(e) Length of stay in Baltimore (yrs., mos., or days) 14yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State M.D. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 122 Wash St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SELINA C. SILVA (SELINA C. SILVA)

3 (b) If veteran, name war ----

3 (c) Social Security Account No. No

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife John Silva

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1883

8. AGE: Years 61 | Months 7 | Days 1 | If less than one day: hr. min.

9. Birthplace New York City, N.Y.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Louis Tagliabue
13. Birthplace Italy

MOTHER
14. Maiden Name Dalphina Yismari
15. Birthplace Italy

16 (a) Informant Ruth Gallicia
(b) Address 1532 John street

17 (a) Removal (b) Date thereof 3/3/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Raymond's
Location Bronx, N.Y.

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 118 N. Mt. Royal Ave.

19 (a) 1945 Huntington Williams, Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1 19 45 at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/21 19 45 to 3/1 19 45.
and that I last saw her alive on 3/1 19 45

Immediate cause of death INTESTINAL OBSTRUCTION — Duration

Due to Carcinoma Jejunum (Bilat) with metastasis to gastro-intestinal tract.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/22/45

Major findings of operation: Bilat carcinoma Jejunum with metastasis to gastro-intestinal tract

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Silverfeld

Address West Balt. Gen Hosp. Date signed 3/1/45 M. D.

X

626411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

626411
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 428 E. 20th St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anne Gahagan (ANNIE B. GAHAGAN)
3 (b) If veteran, name war ----- 3 (c) Social Security Account No. no

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife #
6 (c) If alive, give age # years

7. Birth date of deceased (mo., day, yr.) 1/1/1872

8. AGE: Years 73 | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name John Gahagan
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Gortland
15. Birthplace Ireland

16 (a) Informant John J. Gahagan, Jr.
(b) Address 428 E. 20th street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 118 N. Mt. Royal Ave

19 (a) 3-1945 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28 1945 at 3:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20 1945 to 2/28 1945 and that I last saw h[illegible] alive on 2/28/1945.

Immediate cause of death.	Duration
Cardiac decompensation	
Due to Rheumatic fever	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis A. Frank, Jr., M.D.
Address St. Joseph's Hospital Date signed 3/2/45

VS 150

4666 G26412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134a

G26412 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address:
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hines

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-10-91

8. AGE: Years	Months	Days	If less than one day
53	5	18	hr. min.

9. Birthplace N. Ca. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jeff. Stancil
13. Birthplace N. Ca.

MOTHER
14. Maiden Name Mandy Randolph
15. Birthplace N. Ca.

16 (a) Informant Relative
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof March 3, 1945 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Rocky Mount N. Carolina

18 (a) Funeral director Mrs. Robert Ellis Dgt
(b) Address 1129 N. Caroline Street

19 (a) (Date rec'd by registrar) (b) Registrar
MAR 1 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1945 at 5:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3 1945, to Feb. 28 1945 and that I last saw him alive on Feb. 28 1945

Immediate cause of death: Renal insufficiency
Due to: Chronic nephritis
Due to: Bilateral Kidney stones
Other Conditions:

Duration

(Include pregnancy within 3 months of death)
Date of operation 11/21 + 1/8
Major findings of operation: Renal calculi
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J E Rinehart
Address Johns Hopkins Hosp. Date signed M. 2 D. 28

G26413 G26413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 138

Registered No.

JO #92174

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 456 E. Federal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Haywood Scott or Haywood Scott Turbeville or Tubiville

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1893

8. AGE: Years	Months	Days	If less than one day
51	11	28	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Unable to obtain information.
11. Industry or business " " " "

FATHER
12. Name Alec
13. Birthplace Virginia

MOTHER
14. Maiden Name Anna Turbeville
15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 2 45 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Balto
18 (a) Funeral director Rayner Sanders
(b) Address 412 E Preston St
19 (a) (b)
(Filled in by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26, 1945, at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17, 1945 to Feb. 26, 1945 and that I last saw him alive on Feb. 26, 1945

Immediate cause of death	Duration
Heart failure	Days about
Due to Tuberculous Pericarditis	2 years
Due to Peritoneal Tuberculosis	
Other Conditions Pulmonary Tuberculosis Tuberculous prostatitis	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Luis Tabuenca M. D.
Address Baltimore Maryland Date signed 2/26/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 VS 184 Huntington Williams, M.D.

626414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

626414 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (~~yrs.~~ ~~mos.~~, or days) 5 12
(e) Length of stay in Baltimore (yrs., ~~mos.~~, or ~~days~~) 67

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 438 E. 22nd St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Laura A. Piet

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: Harry R. Piet Deceased | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1877

8. AGE: Years 67 | Months 10 | Days 10 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Wife and Mother

11. Industry or business

FATHER
12. Name J. Wilbur Voss
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Thecla Shipley
15. Birthplace Baltimore, Md.

16 (a) Informant Thomas C. Piet
(b) Address 438 E. 22nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 3 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location -

18 (a) Funeral director May M Wedeford
(b) Address 421 E. 22nd St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27 1945, at 8:05 ~~P~~ M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/23 1945, to 2/27 1945, and that I last saw her alive on 2/27 1945.

Immediate cause of death	Duration
Cardio Resp. Failure	
Due to Left Paraplegia	
Due to Rupt. Middle Cerebral Embolus	
Due to Post Operative Cerebral Hemiplegia (Strangulated Incarcerated Hernia)	
Other Conditions Myocardial Degeneration	

(Include pregnancy within 3 months of death)

Date of operation 2/23/45
Major findings of operation: Post Operative Incarcerated Strangulated Hernia
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert B McFadden M.D.
Address St. Joseph's Hosp. Date signed 2/28/45

VS 150

G26415 BALTIMORE CITY HEALTH DEPARTMENT G26415

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 6 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3603 Forest Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Altmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Fritz Altman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Wichtig
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs Elsa Nathan

(b) Address 3603 Forest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-45 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location

18 (a) Funeral director Jack Peirce Inc

(b) Address 1439 E. Balto. St

19 (a) MAR 1-1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28 1945, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9 1945 to 2/28 1945, and that I last saw h alive on 2/28 1945.

Immediate cause of death Cardio-Resp Failure — Duration

Due to Coronary Thrombosis Coronary Occlusion

Due to Hyp C-V Dis

Other Conditions Pulm. Infarction

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Johnson M. D.
Address Sinai Hosp. Date signed 3/1/45

G26416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G26416 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Lagman
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 Gruton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isedor Diamond

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married.
6 (b) Name of husband or wife: Yetta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 57 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Abraham
13. Birthplace Russia.

MOTHER
14. Maiden Name Anna
15. Birthplace Russia.

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Sons
(b) Address 1439 E. Balto St.

19 (a) MAR 1 1945 (date received by registrar) (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1945, at 1:5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/26 1945, to 3/1 1945, and that I last saw him alive on 3/1 1945.

Immediate cause of death Acute Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Burch W Baldwin M. D.
Address West Baltimore General Hosp Date signed 3/1/45

Huntington Williams Registrar

G26417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G26417 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address U. S. Marine Hospital
(c) Hospital or institution: Wyman Park Drive & 31st Street
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 1/19/45
(e) Length of stay in Baltimore (yrs., mos., or days) Since 1/19/45

2. USUAL RESIDENCE OF DECEASED:
(a) State N.J. (b) County
(c) City or town Bivalve
(If outside city or town limits, write RURAL and give town)
(d) Street No. -
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER WELLS DANZENBAKER

3 (b) If veteran, name war -

3 (c) Social Security Account No. 143-12-8013

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/5/1876

8. AGE: Years	Months	Days	If less than one day
68	2 1	23	hr. min.

9. Birthplace Dearfield, N. J.
(Town, county, and state)
10. Usual Occupation Captain
11. Industry or business Merchant Marine

FATHER
12. Name Louis Danzenbaker
13. Birthplace N.J.

MOTHER
14. Maiden Name Sallie Ogden
15. Birthplace N.J.

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) 3/3/45 (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location [illegible]

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) 3/1/45 (b) [illegible]
(Date received by registrar)

MAR 1 1945

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Feb. 28, 1945 at 10:59 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19, 1945 to Feb. 28, 1945 and that I last saw him alive on Feb. 28, 1945.

	Duration
Immediate cause of death Coronary occlusion	Unk.
Due to Arteriosclerotic heart disease	Unk.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Jones M. D.
Address Baltimore, Md. Date signed 3/1/45

Huntington Williams, M.D.

MS-58435

G26418 ✓ G26418

G26418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - 5 - ---
(e) Length of stay in Baltimore (yrs., mos., or days) About 80 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 E. Lanvale St. (If rural give location)
(e) Citizen of foreign country? ----- (Yes or No)
If yes, name country ------

3 (a) FULL NAME Annie M. Merceret

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ---------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ---------

8. AGE: Years	Months	Days	If less than one day
About 80	---	---	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -------

FATHER
12. Name Louis Merceret
13. Birthplace France

MOTHER
14. Maiden Name Rebecca Baltzell
15. Birthplace Baltimore, Maryland

16 (a) Informant Miss Natalie M. Merceret
(b) Address 2802 St. Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) (Date rec'd by registrar MAR 1 1945) (b) Filed by Worthington for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28th 1945, at 12-45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct- 1944, to Feb 28th 1945, and that I last saw her alive on Feb-27th 1945.

Immediate cause of death Carcinoma of the intestines — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Wilson Wurst M. D.
Address 3005 St Paul St. Date signed 3-1-45

VS 150

G26419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G26419

Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 919 S. Paca Street
(c) Hospital or institution: 21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 919 S. Paca St. (If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E. Smith

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.) December 25, 1871

8. AGE: Years	Months	Days	If less than one day
73	2	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Sexton
11. Industry or business Retired

FATHER
12. Name Jacob Smith
13. Birthplace Maryland

MOTHER
14. Maiden Name Eliza Merson
15. Birthplace Maryland

16 (a) Informant Mrs. Hilda Somerlock
(b) Address 3515 Link Avenue

17 (a) Burial (b) Date thereof 3-3-45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Guy H. Schwartz
(b) Address 2101 Frederick Ave.

19 (a) Date received by registrar Huntington Williams, M.D.
MAR 2 1945
46 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 1945, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1944 to Feb 26 1945, and that I last saw her alive on Feb 26 1945

	Duration
Immediate cause of death Pneumonia Influenza	2
Due to	
Due to Cardiac Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leo Kaczanowski M. D.
Address 715 W Pratt Date signed 3/6/45

G266420 Harvell ✓ G266420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1036 Penna. Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1036 Penna Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Harvell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1903

8. AGE: Years 41 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name James Harvell
13. Birthplace

MOTHER 14. Maiden Name Lucinda
15. Birthplace Va.

16 (a) Informant Sereng Harvell
(b) Address 1036 Penna. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director C. Halstead
(b) Address 918 Druid Hill Ave

19 (a) MAR 2 - 1945 (Date rec'd by registrar) (b) Signature for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28, 1945 at 4 40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/24/44 to 2/27/45 and that I last saw live on 2/27/45

Immediate cause of death Coronary Thrombosis

Due to Pneumonia

Due to " " Multiple Hematomata

Other Conditions Hypostatic Bronchitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(e) Means of injury

23. Signature Dr. Barksdale

Address 526 N. Carey Date signed 3/4/45 M. D.

VS 150

626421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 626421 (over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. + Linden Ave.
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 - 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1336 Hollins St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie E. Kelch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Widowed

6 (b) Name of husband or wife James Thos. Kelch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2nd 1881 1886

8. AGE: Years	Months	Days	If less than one day
59 64	0	26	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name James Bolling
13. Birthplace N.C.

MOTHER
14. Maiden Name Frances (Unknown)
15. Birthplace N.C.

16 (a) Informant Raymond M. Kelch
(b) Address 1336 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/45 (month) (day) (year)
(c) Cemetery ~~as crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (a) MAR 2 - 1945 (Registered by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28 1945 at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 1945, to 2/28 1945, and that I last saw her alive on 2/28 1945.

Immediate cause of death Atypical Pneumonia — Duration

Due to

Due to

Other Conditions Hypertension C.V. Disease Fractured ribs
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Feb. 1945 at M
(c) Where did injury occur? 1336 Hollins St.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At home (Specify type of place) While at work? No
(e) Means of injury Slipped & fell on icy -

23. Signature Martin E. Brooks M. D.
Address Md. Gen'l Hospital Date signed 2/28/45

affirmed by Thomas J. Martin, M.D.

G26422 Edward Novak Md Lic Bldg Pr 6673 ✓ G26422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G26422

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3106 Louise Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 Louise Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kenneth E. MacLeod

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ or wife Celista E MacLeod

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21st 1859

8. AGE: Years	Months	Days	If less than one day
85	6	7	hr. min.

9. Birthplace Liverpool - Nova Scotia
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business —

FATHER
12. Name Stephen MacLeod
13. Birthplace Nova Scotia

MOTHER
14. Maiden Name Sappha Daley
15. Birthplace Nova Scotia

16 (a) Informant Mrs Bertha M. Ferguson
(b) Address 3106 Louise Ave

17 (a) Burial (b) Date thereof 3/2/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) MAR 2 - 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28th 1945, at 8 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1944, to Feb. 28 1945, and that I last saw him alive on Feb. 27 1945.

Immediate cause of death Arteriosclerosis

Duration 1 Y

Due to

Due to

Other Conditions Chronic myocardial degeneration.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Novak M. D.

Address Date signed

VS 150

97

G26423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 75B

Registered No. G26423

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fulton and Madison
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo. 27 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5258 Cordelia Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy E. Gordon

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16th 1925

8. AGE: Years	Months	Days	If less than one day
19	4	12	hr. min.

9. Birthplace Jacksonville Fla.
(Town, county, and state)
10. Usual Occupation Student Nurse
11. Industry or business Md. Genl Hospital

FATHER
12. Name William C. Gordon
13. Birthplace Chicago Ill

MOTHER
14. Maiden Name May B. Butts
15. Birthplace Granite Md.

16 (a) Informant William C. Gordon
(b) Address 5258 Cordelia Ave

17 (a) Burial (b) Date thereof 3/3/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 MAR 2 - 1945 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-28 1945, at 8:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 1944, to 2-28 1945, and that I last saw her alive on 2-28 1945.

Immediate cause of death Peripheral circulatory failure — Duration
Due to Generalized debilitation
Due to Battis disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. L. McConnell M. D.
Address M-4-74 Date signed 3-25-45

G26424

JL - 87665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. G26424

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 - 1 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 340 Stinson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolph W. Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.
nil	none

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
M	W	Widowed

6 (b) Name of ~~husband or~~ wife Rosalie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1877

8. AGE: Years	Months	Days	If less than one day
67	8	6	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Elevator Operator
11. Industry or business Belvedere Hotel

FATHER
12. Name William M. Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Elizabeth Schiminger
15. Birthplace Md.

16 (a) Informant B. C. Hospital Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/3/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 MAR 2 - 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27, 1945, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1944, to Feb. 27 1945, and that I last saw him alive on Feb. 27 1945.

Immediate cause of death	Duration
Pulmonary tuberculosis	1 yr
Due to	
perforating gastric ulcer walled off against liver	3 mo
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Dalton M. D.
Address Balto City Hosp Date signed 2/28/45

VS 150

425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 186a

Registered No. 626425

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d & Calvert
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 da
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore county
(c) City or town ~~Baltimore~~ Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5907 Edmonson
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MR. Isaac Stoneglass
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: Wht
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Eva Stoneglass
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) ?
8. AGE: Years 81 | Months ? | Days ? | If less than one day ... hr. ... min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace

16 (a) Informant Mrs. Stone
(b) Address 926 26th St NW Atlanta Ga

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-45 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Ellicott City Md

18 (a) Funeral director Eugene Feeney
(b) Address Catonsville Md

19 (a) MAR 2 - 1945 (Date rec'd by Registrar) Hunting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-1 1945 at 3:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-11 1945, to 3-1 1945, and that I last saw h.m alive on 3-1 1945.

Immediate cause of death Respiratory Failure — Duration

Due to Bronchopneumonia

Due to Inactivity + Stasis

Other Conditions Fracture neck of Femur-Left (Include pregnancy within 3 months of death)

Date of operation 2-22-45

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 2-10-45 at — M
(c) Where did injury occur? Catonsville, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Pt. fell in home.

23. Signature John D. Morris, MD M. D.
Address CMH. Date signed 3-1-45

For H. B. McNally, by Howard J. Williams, M.D.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. 6269 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1512 Hanover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Watson Lugenbeel

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Mary Waefe.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1875

8. AGE: Years	Months	Days	If less than one day
69	2	26	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Conductor
11. Industry or business B & O R.R.

FATHER
12. Name Jacob Lugenbeel
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Alexander
15. Birthplace Md.

16 (a) Informant Family
(b) Address 1512 Hanover St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3-3-45 (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location Frederick Rd.

18 (a) Funeral director James L. McCurdy
(b) Address 429 E. Fort Ave.

MAR 2 - 1945 (Date filed by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1945 at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1945, to Feb. 28 1945, and that I last saw him alive on Feb. 27 1945.

Immediate cause of death Myocarditis
Insufficiency — Duration 4 mos

Due to Arterio Sclerosis — years

Due to High Blood Pressure — years

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred L. Zimmerman M. D.

Address 9955 Harford Rd Date signed 2-28-45

VS 150

G26427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G26427

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2627 Ridgley Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) ~~Single~~, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bernard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1911

8. AGE: Years 33 | Months 9 | Days 17 | If less than one day: hr. min.

9. Birthplace Summonsville, S.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Canning factory

FATHER
12. Name Charles Axwell
13. Birthplace Summonsville, S.C.

MOTHER
14. Maiden Name Josephine White
15. Birthplace Summonsville, S.C.

16 (a) Informant Bernard Smith
(b) Address 2627 Ridgley Ave.

17 (a) Burial (b) Date thereof 3-2-1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Summonsville, S.C.

18 (a) Funeral director Murray Bros. & Holland
(b) Address 1631 Druid Hill Ave.

MAR 2 - 1945 (b) Huntington Williams
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27, 1945, at 12:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1945, to 2/27 1945, and that I last saw her alive on 2/27 1945.

Immediate cause of death: Bronchogenic Carcinoma — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James D. Carr

Address Provident Hospital Date signed 2/27/45

X

66428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 626420

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alice T. Lehman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Negro | 6 (a) ~~Single~~, married, widowed or divorced. married

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3d 1881

8. AGE: Years 63 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Natalie, Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Lonza Still
13. Birthplace Natalie, Va

MOTHER
14. Maiden Name Mary Casaley
15. Birthplace Natalie, Va

16 (a) Informant William T. Lehman
(b) Address 1130 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-02-'45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Memorial Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs Lee W. Holland
(b) Address 1631 Druid Hill Ave

19 (a) MAR 2 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27, 1945, at 3:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/26 1945 to 2/27 1945, and that I last saw her alive on 2/27 1945.

Immediate cause of death	Duration
Hypertensive Arteriosclerotic Heart Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James P. Carr, M.D.
Address Provident Hospital Date signed 3/1/45

G56429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G56429

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Maryland General Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Roslyn Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Bettie Lee Caulk

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Edward August Caulk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1868

8. AGE: Years	Months	Days	If less than one day
76	7	21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James R. Marley
13. Birthplace Reisterstown, Md.

MOTHER
14. Maiden Name Nancy McElhenny
15. Birthplace Balto., Md.

16 (a) Informant Miss Helen Caulk
(b) Address 2206 Roslyn Ave.

17 (a) Burial (b) Date thereof 3/3/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory WESTERN CEM.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 2 - 1945 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-28 1945 at 3.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-11 1945, to 2-28 1945, and that I last saw her alive on 2-28 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to HCVD	
Due to	
Other Conditions hypostatic pneumonia 10 day	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. E. Chandler, Jr. M.D.
Address Md. Gen. Hosp. Date signed Mar 2 1945

G26430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V1631

Registered No. G26430

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 2200 Poplar Grove St 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 Poplar Grove St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James R. Fahey

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 133-09-8804

4. Sex: m

5. Color or race: w

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Etta A. Fahey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1879

8. AGE: Years 66 | Months 0 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired - Realtor

11. Industry or business Self

FATHER
12. Name Patrick Fahey
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Baldwin
15. Birthplace Ireland

16 (a) Informant Mrs. Veronica Litsinger
(b) Address 2200 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAR 2 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-28- 1945 at 7 40 P.M

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Life death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to Carbon Monoxide gas.

Due to

Other Conditions Mental despondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-28-45 at 7:40 P. M.
(b) Where did injury occur? 2201 Poplar Grove St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Kitchen Stove-Burners unlit

23. Signature Robert L. Graham M.D. (Medical Examiner.)
Date signed March 1st 1945

correct age is especially important. Physicians: please write

VS 151

G26431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G26431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1517 Clayton Ave
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-3
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 Clayton Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John P. Cooper

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	w	widowed

6 (b) Name of husband or wife Mary B. Cooper
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 22, 1871

8. AGE: Years	Months	Days	If less than one day
74	1	6	hr. — min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John P. Cooper
13. Birthplace Bozman Md

MOTHER
14. Maiden Name Mary Emily Ledeuner
15. Birthplace Bozman Md.

16 (a) Informant Estate of Cooper
(b) Address 1517 Clayton Ave

17 (a) Removal (b) Date thereof 3 | 3 | 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bozman Cem.
Location Bozman, Talbot Co., Md

18 (a) Funeral director Wm. J. Tilden & Sons
(b) Address Bel Air Md

MAR 2 - 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1945, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1945 to Feb 28 1945; and that I last saw h[illegible] alive on Feb 28 1945.

Immediate cause of death	Duration
Ch. Myocarditis	1943
Due to Ch. Interstitial Nephritis	1943
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jane E. Brown
Address 1663 Mosher St Date signed 3/2/45 M.D.

6432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 6432

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 E. Biddle St.
(c) Hospital or institution:

10-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD L. COOK

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 705-10-8235

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Alice V. Cook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9, 1888

8. AGE: Years	Months	Days	If less than one day
56	11	19	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Brakeman
11. Industry or business Western Md. R. R.

FATHER
12. Name Coleman Cook
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Alice V. Cook
(b) Address 405 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAR 2 - 1945 (Date rec'd by registrar) (by) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28, 1945, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/26 1945 to 2/28 1945, and that I last saw h. I'm alive on 2/26 1945

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to Arteriosclerotic Cardiac	?
Due to Vascular Disease	?
Other Conditions Cachexia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph S. Blum, M.D.
Address 206 E. Preston St. Date signed 3/2/45

VS 150

G6433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G6433

1. PLACE OF DEATH: D.O.A

(a) Baltimore City, Maryland

(b) Street address 2410 Maryland Ave

(c) Hospital or institution: at Home 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0

(e) Length of stay in Baltimore (yrs., mos., or days) 34 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore City

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2410 Maryland Ave

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Cora Wickard Gephart

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Templeton D. Gephart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14 1864

8. AGE: Years 81 | Months 0 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER 12. Name Levi Mikard

13. Birthplace Frederick Co. Md.

MOTHER 14. Maiden Name Amanda Boogher

15. Birthplace Frederick Co. Md.

16 (a) Informant Mrs. Hazel Gephart (daughter)

(b) Address 2410 Md. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-45 (month) (day) (year)

(c) Cemetery or crematory Rose Hill

Location Cumberland

18 (a) Funeral director Stewart Mortuary Co.

(b) Address 108 W. Main St.

MAR 2 - 1945 (Date rec'd by registrar)

Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 28 19 45, at 5-40 P M

21. I certify that I took charge of the remains described above, held an Inquiry - Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ... at ... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Chester L. Sullivan M.D. Medical Examiner.

Date signed 3-28-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G26434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

42 B

Registered No. G26434

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4002 Dorchester Rd
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 5-10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4002 Dorchester Rd (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME George Kent

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth H Kent
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Dec 15 1869

8. AGE: Years 75 | Months 2 | Days 14 17 | If less than one day — hr. — min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Accountant
11. Industry or business Sam'l Ready School

FATHER
12. Name Benj Kent
13. Birthplace Eng Land

MOTHER
14. Maiden Name Susan Kent
15. Birthplace Eng Land

16 (a) Informant Mrs Eliz. H Kent - wife
(b) Address 4002 Dorchester Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Stewart & Company
(b) Address 102 W North Ave.

19 (a) MAR 2 - 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1945; at 5:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1945 to March 1 1945 and that I last saw him alive on Feb 27 1945.

Immediate cause of death	Duration
Tumor, central arteriosclerosis	
Due to Hypertension with Insufficiency	
Due to Chr myocardial degeneration	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry C Hyde

Address 1100 E North Ave Date signed 3/2/45

VS 150

Harry C Hyde

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 635

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution:
Church Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days) 7 d

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. Carvel Hall
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Margaret Jupp

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Captain Stanley Jupp

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-2-'09

8. AGE: Years 35 | Months 1 | Days - | If less than one day ... hr. ... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Captain V. McNair
13. Birthplace Md

MOTHER
14. Maiden Name Agnes Dunn
15. Birthplace Md

16 (a) Informant Mrs. V. McNair
(b) Address Annapolis, Md

17 (a) Burial (b) Date thereof Mar 3, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Naval Cemetery
Location Annapolis Md.

18 (a) Funeral director John M. Taylor
(b) Address Annapolis Md.

19 (a) 1945 Arlington Williams M.D.
(Date rec'd by registrar) Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1945 at 1 yr A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-14 1945 to 3-2 1945 and that I last saw her alive on 3-1 1945

Immediate cause of death Carcinoma of the breast, metastasis — Duration 4 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marvin N. Davis M. D.
Address Church Home Date signed 3-2-45

G26436 G26436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 V

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 919 Argyle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Pates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace Spartansburg, S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Willie Ozella Wilson
(b) Address 911 Shields Pl.

17 (a) Burial (b) Date thereof 3/2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1005 Druid Heights Ave

19 (a) 3/2/45 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1945, at 4:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Syphilitic aortitis & valvulitis; marked cardiac hypertrophy & dilatation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Feb. 26 1945.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V131a

Registered No. G66437

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Date of birth and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 815 n. Carey St
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 n. Carey St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Kate A. Baucum

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	colored	married

6 (b) Name of husband or wife James Baucum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9 1879

8. AGE: Years	Months	Days	If less than one day
66 65	1	18	hr. min.

9. Birthplace N. C (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Henry Chase
13. Birthplace N. C

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant James Baucum
(b) Address 815 n. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus cem
Location md

18 (a) Funeral director George H. Nelson
(b) Address 1303 Presstman St

19 (a) MAR 2 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1945, at 10.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2-1944 to 2-27-1945, and that I last saw h alive on 2-26-1945

Immediate cause of death	Duration
Chronic Cardio Vascular Renal	1 year
Due to Visceral Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Baucum
Address 600 Hamburg St Signed 3/5/45

VS 3

26438

HEALTH DEPARTMENT—CITY OF BALTIMORE

26438

CERTIFICATE OF DEATH

83a

1. PLACE OF DEATH — Registered No.

CITY OF BALTIMORE: (No. 1813 Pine St., ( ) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Jeanie Miller

If U.S. Veteran specify WAR ...

(a) Residence: No. 1913 Pine St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William Miller.

6. DATE OF BIRTH (month, day, year) 1845

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
50			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ...

10. Date deceased last worked at this occupation (month and year) ...

11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) (State or country) Mt. Holly, N. C.

FATHER

13. NAME Rufus Henderson.

14. BIRTHPLACE (city or town) (State or country) Mt. Holly, N.C.

MOTHER

15. MAIDEN NAME Binary.

16. BIRTHPLACE (city or town) (State or country) ...

17. INFORMANT Mrs. Carrie Green.
(Address) ...

18. BURIAL, CREMATION, OR REMOVAL Burial
Place Mt Auburn Date March 2 1945

19. UNDERTAKER Mrs Katie R Williams
(Address) 322 N Schroeder St.

20. FILED 3/2/45 Huntington Williams Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb 26 1945

22. I HEREBY CERTIFY, That I attended deceased from Feb 23 1945 to Feb 26 1945

I last saw h[illegible] alive on Feb 26 1945. Death is said to have occurred on the date stated above, at ... m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Hemorrhage Brain	
Other contributory causes of importance:	

Was an operation performed? — Date of —

For what disease or injury? ...

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) Jack C Wagner M. D.

(Address) 3027 Seabury

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of OCCUPATION is very important. See instructions on back of certificate.

X

6439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

Registered No. G 6439

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene
(c) Hospital or institution:
Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13da
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 Woodstock Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Veronia Mary Kucera

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Anton Kucera
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) — 12/20/93

8. AGE: Years	Months	Days	If less than one day
51	2 —	-8	— hr. — min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business —

FATHER
12. Name Frederick Korman
13. Birthplace Unknown

MOTHER
14. Maiden Name " "
15. Birthplace Germany

16 (a) Informant Husband
(b) Address 3306 Woodstock Ave City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/45 (month) (day) (year)
(c) Cemetery or ~~xxxxx~~ Baltimore
Location Baltimore, Maryland

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

MAR 2 — 1945 Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1945, at 1:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 16 1945 to Feb. 28 1945, and that I last saw her alive on Feb. 28 1945

Immediate cause of death	Duration
medullary compression	
Due to brain tumor	
Due to —	
Other Conditions	over

(Include pregnancy within 3 months of death)
Date of operation Feb. 28, 1945
Major findings of operation: increased intra-cranial pressure
of autopsy: not yet reported.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Lyle Bruce M. D.
Address Univ. Hosp. Date signed 2-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

6264[illegible]40

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. 626440

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2528 E. Eager Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2528 E. Eager Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edward Piotrowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Josephine (nee Rapert)
6 (c) If alive, give age yrs.

7. Birth date of deceased (mo., day, yr.) July 1, 1884

8. AGE: Years	Months	Days	If less than one day
60 yrs.	7	27	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation
11. Industry or business Park Board

FATHER
12. Name unknown
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs. L. J. Wesolowski (Dgt)
(b) Address 8402 Beryl Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

MAR 2 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1945, at 11:20 p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27 1945 to Feb. 28 1945 and that I last saw h[illegible] alive on Feb. 26 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 hrs.
Due to Hypertension	
Due to Arteriosclerosis	5 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 5707 Beryl Rd Date signed 3-1-45

VS 150

626441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No. 626441

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 719 Lennox st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 719 Lennox St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William T. Lyles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or wife~~ Benjamina Lyles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23rd 1868

8. AGE: Years	Months	Days	If less than one day
76	8	8	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation Railroader
11. Industry or business B & O R.R.

FATHER
12. Name Wm T. Lyles
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Jane Clare
15. Birthplace Calvert Co. Md.

16 (a) Informant Mrs Benjamina Lyles
(b) Address 719 Lennox St.

17 (a) Burial (b) Date thereof 3/3/45
(Burial, ~~cremation or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) MAR 2 - 1945 Signature for Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 1st 1945, at 6 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 22 1945 to Mch 1 1945 and that I last saw h~~er~~ alive on Feb 28 1945

Immediate cause of death	Duration
Cerebral thrombosis	8 days
Due to Arteriosclerosis	15 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address 2818 Pr. Chas. Rd. Date signed 3/7/45 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D26442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. D26442

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 Gwynn Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Gwynn Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Salvatore Liberto

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Francesca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Italy (town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Giovanni Liberto
13. Birthplace Cefalu Italy

MOTHER
14. Maiden Name Salvatora Liberto
15. Birthplace Cefalu Italy

16 (a) Informant Angelina Liberto
(b) Address 415 Gwynn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location 4300 Old Frederick Road

18 (a) Funeral director Joseph Savage Sons
(b) Address 20 S Fremont Ave

19 (a) (b)
(Date received by registrar) Registrar

MAR 2 - 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27, 1945, at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26 1945 to Feb. 27, 1945 and that I last saw him alive on Feb. 27, 1945

Immediate cause of death	Duration
Acute Cardiac Dilatation.	2 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ed Tompsett M.D.

Address Medical Arts Bldg Date signed 3/1/45

X

G26443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G26443

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 N. Lunsdowne Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 N. Lunsdowne Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Jackman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widow

6 (b) Name of husband or wife John F. Jackman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1. 1867.

8. AGE: Years	Months	Days	If less than one day
77	10	26.	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Richard Straker
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Dont. Know
15. Birthplace Balto Md

16 (a) Informant Leo Jackman
(b) Address 5 N. Lunsdowne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 3 /45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road
18 (a) Funeral director Martin L. Cypress
(b) Address 1102 Forrest St.
19 (a) MAR 2 - 1945 (Date rec'd by registrar) (b) Hunt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1945, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1945, to Feb 27 1945, and that I last saw h.e.r alive on Feb. 27 1945.

Immediate cause of death	Duration
Acute pulmonary Edema	
Due to	
Chronic Myocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene Zeller, M.D.
Address 2739 Eastern Ave Date signed 3/1/45 M. D.

VS 3

626444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 626444

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2121 Homewood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 Homewood Ave.
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Boucher

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 2-1872

8. AGE: Years	Months	Days	If less than one day
72 73?	3	29	hr. min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business Home

FATHER
12. Name Patrick Murray
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Bridgit Feeley
15. Birthplace Ireland

16 (a) Informant J. Murray Sweeney
(b) Address 310 Fairdale Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March. 5-45 (Month) (day) (Year)
(c) Cemetery or crematory New Cath. Cem.
Location Old Frederick Rd.

18 (a) Funeral director John F. Moran
(b) Address 4201 Gramercy Ave. Huntington for Williams, Md.

MAR 2 - 1945 (b)
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1945, at ? M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Davis M.D.
Medical Examiner.
Date signed 3/1/45

VS 151

93D

G26445 ✓ G26445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 303 N. Highland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 N. Highland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Joyce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Edward A. Joyce

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11 1898

8. AGE: Years 46 | Months 10 | Days 20 | If less than one day hr. min.

9. Birthplace Balto., Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER | FATHER

12. Name Berthold Hubbert

13. Birthplace Hungary

14. Maiden Name Amelia —

15. Birthplace Hungary

16 (a) Informant Edward A. Joyce

(b) Address 303 N. Highland Ave

17 (a) Burial Junior (b) Date thereof 3-4-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship

Location

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) MAR 2 - 1945 (b) Registrar

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-1-45 19 , at 8P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 30 to 3/1 19 45, and that I last saw her alive on 3/1 19 45

Immediate cause of death: Acute Dilatation of Heart — Duration Instantaneous

Due to Chronic Interstitial Nephritis

Due to Bronchial Asthma

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Dwight L. Snyder

Address 5372 E Balto St Date signed 7/2/45

G26446 — BALTIMORE CITY HEALTH DEPARTMENT — G26446 — Registered No.

CERTIFICATE OF DEATH 33B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St.
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis (If outside city or town limits, write RURAL and give town)
(d) Street No. 93 Main St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Estelle Wolod.
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Sngl.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10-9-44
8. AGE: Years | Months 4 Mo | Days 23 | If less than one day hr. min.
9. Birthplace Annapolis, Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Meyer Wolod
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Bloom
15. Birthplace Md

16 (a) Informant Meyer Wolod
(b) Address 93 Main St Annapolis, Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-45 (month) (day) (year)
(c) Cemetery or crematory Bellevue Memory Park Location
18 (a) Funeral director Dodd Sons Inc
(b) Address 4439 E. Balto. St
19 (a) (Date rec'd by registrar) (b) Registrar

MAR 2 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2/45 19 , at 9:00 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 , and that I last saw her alive on 3/2/45 19 .

Immediate cause of death Respiratory failure - meningitis - Hemophilus Influenzae - Type B — Duration
Due to Internal hydrocephalus
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature D.W. Mintz M. D.
Address Univ. Hosp. Date signed 3/2/45

Huntington Williams, M.D.

X

G26447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

Registered No. G26447

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 d St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2103 Brookfield Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Flossie Thompson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1891

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business

FATHER
12. Name ?
13. Birthplace Maryland

MOTHER
14. Maiden Name ?
15. Birthplace Maryland

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

MAR 2 - 1945
(Date rec'd by registrar)

JOHN HOPKINS MEDICAL SCHOOL MAR 2 - 1945 Commissioner of Health
Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1945 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 6 1945 to Feb. 20 1945 and that I last saw him alive on Feb. 20 1945

Immediate cause of death	Duration
Toxemia	
Due to 2nd, 3rd & 4th Degree Burns of legs.	
Due to	
Other Conditions Arteriosclerotic Heart Disease; Chronic Nephritis (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 12/2
(a) Accident, suicide, or homicide accidental
(b) Date of occurrence 2-6-45 at P. M
(c) Where did injury occur? 2103 Brookfield (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Scalding, opened in bed.

23. Signature Mitchell A. Sprague M.D.
Address U.M.H. Date signed 2-20-45

Approved: J. R. Davis M.D. per Robert Lee Graton 4/23/45

VS 150

626448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

626448 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 213 S. Eutaw St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Tyler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 70 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 2 - 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 2 - 1945 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19 1945, at 7:55 M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 2/19/45

VS 151

2351

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

626449 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1917 E. PRATT ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 E. PRATT ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE A. LEWANDOWSKI

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife SOPHIA LEWANDOWSKI
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 11 1890

8. AGE: Years	Months	Days	If less than one day
54	10	17	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation RIGGER
11. Industry or business

FATHER
12. Name LAWRENCE LEWANDOWSKI
13. Birthplace POLAND

MOTHER
14. Maiden Name MARY URBANIK
15. Birthplace POLAND

16 (a) Informant SOPHIA LEWANDOWSKI (WIFE)
(b) Address 1917 E. PRATT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 3/45 (month) (day) (year)
(c) Cemetery or crematory ST. STANASLAUS
Location DUNDALK AVE.

18 (a) Funeral director Lilly and Geiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) MAR 2 - 1945 (Date received by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 28 1945 at 7/30 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1943 to Feb. 28 1945 and that I last saw h-- alive on Feb 26 1945

Immediate cause of death	Duration
Pneumonia Nephritis	22 mos
Myocarditis	22 mos
Due to Anasarca	" "
Secondary Anemia	" "
Due to	
Other Conditions Pulmonic tuberculosis due to capillary changes	22 mos

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: — —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature G. F. Rice M. D.
Address 24 S. Broadway Date signed Feb 28/45

X

626450 ✓ 626450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 902 Greenmount Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie Boone Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3rd 1893

8. AGE: Years 51 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Birmingham Ala. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Warren Herring
13. Birthplace Ala.

MOTHER 14. Maiden Name Charlotta Carter
15. Birthplace Ala.

16 (a) Informant Joseph Johnson
(b) Address 902 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/45 (month) (day) (year)
(c) Cemetery or crematory Englewood
Location Chicago Ill.

18 (a) Funeral director Byron & Mary Wright
(b) Address 721 Edgrath St Balto, Md.

19 (a) (Date received by registrar) (b) Huntington Willi Registrar

MAR 2 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 1945, at 9:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/24 1945 to 2/26 1945. and that I last saw h- alive on 2/26 1945.

Immediate cause of death: Cerebral Hemorrhage
Left - Hemiplegia
Due to Nephritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen A. Lapsley
Address 8111 W. Broad St Date signed 3/1/45

X

G26451

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

G26451 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1623 E. Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 1623 E. Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Stewart Mary Virginia Stewart

3 (b) If veteran, name war —
3 (c) Social Security Account No. None.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Willie H. Stewart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 25 1893

8. AGE: Years 52 | Months 1 | Days 6 | If less than one day hr. min.

9. Birthplace Milton N. C. (Town, county and state)

10. Usual Occupation At - Home.

11. Industry or business

FATHER
12. Name Chestnut Stamps
13. Birthplace Unknown

MOTHER
14. Maiden Name Lydia —
15. Birthplace Unknown

16 (a) Informant Virginia Shepherd
(b) Address 1623 E. Monument

17 (a) Interment (b) Date thereof 3/7/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Suffolk Va.
Location

18 (a) Funeral director Asbury H. Young
(b) Address 604 N. Carrollton Ave

MAR 9 - 1945 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1945 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14 1945 to 3/1 1945 and that I last saw h[illegible] alive on 3/1 1945

Immediate cause of death
Cerebral Hemorrhage & Hemiplegia — Duration 2/13/45
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hart L. Lafond M.D.
Address 822 N. Bond St Date signed 3/3/45

626452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

626452 Registered No. 1318

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4303 Elderon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4303 Elderon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Katharine Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Matthias Harris

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) June 17th 1870

8. AGE: Years 74 | Months 8 | Days 11 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown Rigney
13. Birthplace Maryland.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Matthias Harris
(b) Address 4303 Elderon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John F. Kenny Inc, Earl Hess
(b) Address 715 Light St.

19 (a) 1945 (Date received by registrar) Huntington Williams, Registrar

MAR 2

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28th 1945 at 12th AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1944 to 2/27 1945. and that I last saw her alive on 2/27 1945.

Immediate cause of death Chronic nephritis — Duration 2 yrs

Due to

Due to

Other Conditions Cardiac arrhythmia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Russell, M.D.
Address 3908 Keeneland Date signed 3/2/45

Balto 15 Md. X

VS 150

G-26453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G-26453

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes S. Martin

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed
6 (b) Name of husband or wife: Albert Martin
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): May 10th 1880
8. AGE: Years: 64 | Months: 11 | Days: 22 | If less than one day: hr. min.
9. Birthplace: Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Isaac Bluely
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Margaret "
15. Birthplace: "

16 (a) Informant: William J. Rauschling
(b) Address: 3218 Willoughby Ave Parkville Md.
17 (a) Final (Burial, cremation, or removal) (b) Date thereof 3/6/45 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Parkville Md
18 (a) Funeral director: Milton Lockhart
(b) Address: 1217 E Lexington St
19 MAR 3 - 1945 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2 1945, at 8:45 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 2/22 1945, to 3/2 1945, and that I last saw her alive on 3/2 1945.

Immediate cause of death	Duration
Cardio Resp Failure	
Due to Cerebral Hemorrhage	
Due to Uremia	
Other Conditions Pyelonephritis Hypertension	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. Seaman M. D.
Address 1 Hopkins Place Date signed 3/4/45

G26454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

Registered No. G26454

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 McAleer Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAPPE, HERMAN

3 (b) If veteran, name war: ~~11~~

3 (c) Social Security Account No. ~~xxx~~

4 Sex: Male | 5 Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or~~ wife: Maria Lafaye

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12th 1870

8. AGE: Years 74 | Months 8 | Days 19 | If less than one day: hr. min.

9. Birthplace: Balto Maryland
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Charles A. Lafaye
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: " "

16 (a) Informant: Mrs. E. Teff
(b) Address: 643 E. 29th St.

17 (a) Burial (b) Date thereof 3/5/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~: London Park
Location: Balto Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St.

MAR 3 - 1945
(a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2 1945, at 2.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1945, to 3/2 1945; and that I last saw h[illegible] alive on 3/2 1945.

Immediate cause of death: Peritonitis
PERITONITIS

	Duration
Due to	4
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 3/2/45

Major findings of operation: Peritonitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elmer Hoffman, M. D.
Address Sinai Hospital Date signed 3/2/45

X

626455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 6455

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 910 Chestnut Hill Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 910 Chestnut Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Daniel Ortel

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	nne

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Mary Amelia Ortel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1st 1864

8. AGE: Years	Months	Days	If less than one day
81	2	0	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name (Unknown) Ortel
13. Birthplace "

MOTHER
14. Maiden Name Mary "
15. Birthplace "

16 (a) Informant Elmer J. Ortel
(b) Address 910 Chestnut Hill Ave

17 (a) Burial (b) Date thereof 3/5/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

MAR 3 - 1945 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 1st 1945, at 4a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 19 1945 to Mar 1 1945 and that I last saw him alive on Feb 28 1945

Immediate cause of death	Duration
Cardio-Vascular Hypertension	
Due to Pneumonia	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Homer A. Todd M.D.
Address 735 N. Fulton Ave Date signed 3/2/45

X

G26456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G26456

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Be especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1117 Ridgely

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1117 Ridgely

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Sarah E Baldwin

3 (b) If veteran, name war W

3 (c) Social Security Account No. non

4. Sex Fem'l | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Wdod

6 (b) Name of husband or wife Sommel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1875

8. AGE: Years 69 | Months 69 | Days | If less than one day hr. min.

9. Birthplace France Fra Co Md

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Zachary Jones

13. Birthplace Md

MOTHER 14. Maiden Name Rachel Jackson

15. Birthplace Md

16 (a) Informant Mary Bagley

(b) Address 147 Ridgely Dr

17 (a) Burial (b) Date thereof 3/4/45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Nichols Memorial

Location Odenton Md

18 (a) Funeral director Pullman Co Inc

(b) Address 214 E Lexington (Huntington for Williams, Mgr.)

19 MAR 2 - 1945 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1945, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20/45 19 , to 3/1 19 45

and that I last saw h[illegible] alive on 3/1 19 45

Immediate cause of death Bronchio Pneumonia — Duration 2da

Due to Cerebral Hemorrhage — Duration 2/20/45

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Joseph G Lawlah

Address Washington Blvd Date signed 3/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

Registered No. G26457

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2130 N Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2130 N Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Jeffery

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Calvin R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20 1856

8. AGE: Years 88 | Months 7 | Days 12 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Jacob Bonman
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs Herbert Stallings
(b) Address 2130 N Fulton Ave

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 3/5/45 (month) (day) (year)
(c) Cemetery London Park
Location Balto. Md.

18 (a) Funeral director Wilhelm & Son
(b) Address 1212 E Fayette St

MAR 3 - 1945 (Date rec'd by registrar)

Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1945 at 7 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1943, to Mar 2 1945, and that I last saw h[illegible] alive on Mar 1, 1945.

Immediate cause of death	Duration
Chronic myocarditis.	
Due to	
Other Conditions chr. nephritis.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George E. Shannon M.D.
Address 720 Med. Sta. Bldg. Date signed 3/2/45

935

VS 150

G26458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. G26458

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4651 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4651 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Rosenbrock

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or ~~wife~~: Christian W. Rosenbrock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26th 1861

8. AGE: Years 83 | Months 4 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business At Home

FATHER
12. Name George Miller
13. Birthplace Unknown

MOTHER
14. Maiden Name Margaret Forman
15. Birthplace Balto. Md.

16 (a) Informant Edward T. Rosenbrock
(b) Address 4651 Park Heights Ave

17 (a) Burial (b) Date thereof 3/5/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) MAR 3 1945 Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1945 at 9 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1942 to Feb 28 1945 and that I last saw h.er alive on February 17 1945.

Immediate cause of death	Duration
Mitral insufficiency	7/10/42
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D. Bubert M. D.
Address 4503 Park Heights Ave Date signed 3/2/45

UN 31 A06

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

G26459 Registered No. G26459

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3601 Gruendtsburg Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3601 Gruendtsburg Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles P Englant Jr

3 (b) If veteran, name war W | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 1872

8. AGE: Years 72 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Clerk Clothes

11. Industry or business P.R.R.

MOTHER'S FATHER

12. Name Philip Englant

13. Birthplace Germany

14. Maiden Name Elizabeth Schultz

15. Birthplace Baltimore Md

16 (a) Informant Charles P Englant Jr

(b) Address 3601 Gruendtsburg Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md

18 (a) Funeral director Wilson & Son Inc

(b) Address 1219 E Fayette St

19 (c) MAR 3 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1945, at 4 49 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/31/1936 to 2/27/1945. and that I last saw h.. alive on 27 1935

Immediate cause of death Chronic Myocarditis — | Duration Years

Due to Arteriosclerosis

Due to

Other Conditions Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature J C Oatfield M.D.

Address 3403 Fairview Blvd Date signed 3/2/45

VS 150

G26460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 B

Registered No. G26460

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1626 SHAKESPEARE ST
(c) Hospital or institution: HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE 31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 SHAKESPEARE ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MICHALENA GUTOWSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. – – –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	Widow

6 (b) Name of husband ~~wife~~ STANISLAW 6 (c) If alive, give age Deceased

7. Birth date of deceased (mo., day, yr.) August 1887

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace POLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant BARBARA EWANOWSKI
(b) Address 1626 SHAKESPEARE ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/5/45 (month) (day) (year)
(c) Cemetery or crematory HOLY ROSARY
Location BALTIMORE Md.

18 (a) Funeral director George R. Weber.
(b) Address 705 S ANN ST.

19 (Date received) MAR 3 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 2nd 1945, at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945, to Mar 2 1945, and that I last saw h[illegible] alive on Mar 1 1945.

Immediate cause of death	Duration
Pulmonary Tb. Disease	6-2-43
Cerebral Hemorrhage	10-11-43
Due to Chronic Glomerulo Nephritis	11-15-44
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 842 S Eutaw Date signed 3-2-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

26461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 26461

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Redwood Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 15 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3912 Oakford Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Roger P. Stansbury

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of ~~husband or~~ wife Mary Stansbury
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 3-1901

8. AGE: Years	Months	Days	If less than one day
43	10	25	..... hr. ..... min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Engineman
11. Industry or business Navy Station

FATHER
12. Name Wm. L. Stansbury
13. Birthplace Balto Md

MOTHER
14. Maiden Name Carrie Price
15. Birthplace Balto. Md

16 (a) Informant Mrs. Mary Stansbury
(b) Address 3912 Oakford ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Pikesville Md

18 (a) Funeral director Geo. L. Berger Jr
(b) Address 517 Hollins St Huntington Pittsburgh, Md

19 (a) Filed MAR 8 - 1945 (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27 1945, at 3:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20 1945, to 2-28 1945, and that I last saw h/m alive on 2-27 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C B Jourdet M.D.
Address Univ. Hosp. Date signed 7-2-45

VS 150

X

G26462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49E

Registered No. G26462

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the ... the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1541 E. 29th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1541 E. 29th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: LAURA BELLE HOSHALL

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-03-3196

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alton Y. Hoshall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1901

8. AGE: Years 43 | Months 8 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Albert F. Smith
13. Birthplace Dover, Del

MOTHER
14. Maiden Name Sallie Gibson
15. Birthplace Va.

16 (a) Informant Mr. Alton Y. Hoshall
(b) Address 1541 E. 29th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/45 (month) (day) (year)
(c) Cemetery or crem Greenmount Mausoleum
Location Baltimore, Maryland

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAR 3 - 1945 (Date Rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1945, at 10:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1, 1944, to March 1 1945 and that I last saw h[er] alive on March 1 1945.

Immediate cause of death Carcinoma Broad Ligament — Duration 2 yrs

Due to Metastasis to Lung -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ed L. Zimmerman M.D.
Address 9858 Harford Date signed 9/2/45

VS 150

626463

Dr. Henry Russell
3902 Groveland Ave.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. 626463

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3817 West Garrison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3817 West Garrison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Kirk

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William Albert Kirk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1876

8. AGE: Years	Months	Days	If less than one day
68	9	11	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Benjamin F. Boyd
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant A. Leroy Kirk (Son)
(b) Address 3817 West Garrison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Baltimore, Maryland

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave.

19 (a) MAR 3 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1 1945, at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 1945, to 3/1 1945, and that I last saw her alive on 3/1 1945.

Immediate cause of death Coronary thrombosis — Duration

Due to — Duration

Due to — Duration

Other Conditions Arteriosclerosis — Duration

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bryan Russell M. D.
Address 3902 Groveland Ave Date signed 3/2/45

15 X

G 6464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G 6464

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1324 Luzerne Ave.
(c) Hospital or institution:

9-16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1901 E.31st St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida K.Landon

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1873

8. AGE: Years	Months	Days	If less than one day
71	2	7	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name John Ayers
13. Birthplace not known

MOTHER
14. Maiden Name Susan Williams
15. Birthplace Baltimore Md.

16 (a) Informant Pauline Knopp
(b) Address 1901 E.31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/45 (month) (day) (year)
(c) Cemetery or crematory St.Marys
Location Roland Ave & 39th St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N.Broadway

19 (a) Date received (month) (day) (year) (b) Filed by Huntington Williams, Registrar

MAR 3 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1945, to Feb 28 1945, and that I last saw h[illegible] alive on Feb 20 1945.

Immediate cause of death Acute Cardiac Dilatation — Duration
Due to Hypertension C-V. Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edw. L. Hartman M. D.
Address 4037 Oakland Rd. Date signed 3/2/45

X

G26465

JO #92180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. G26465

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied—the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 22
(If outside city or town limits, write RURAL and give town)
(d) Street No. 814 China St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elzie Kell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife ? (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1888

8. AGE: Years	Months	Days	If less than one day
56	10	22	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Unable to obtain information

11. Industry or business " " " "

FATHER
12. Name Unable to obtain information:
13. Birthplace " " " "

MOTHER
14. Maiden Name " " " "
15. Birthplace " " " "

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore City.

18 (a) Funeral director Joseph A. Lively
(b) Address 401 N. Mount St. Baltimore 23

MAR 3 - 1945 (b) Dist. rec'd (Registrar) Huntington Williams M.D.

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24, 1945, at 8:22 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17, 1945, to Feb. 24, 1945, and that I last saw him alive on Feb. 24, 1945.

Immediate cause of death: Bronchopneumonia — Duration: 5 Days

Due to

Due to

Other Conditions Strangulated Hernia — Duration: 1 wk.
(Include pregnancy within 3 months of death)

Date of operation 2-17-45

Major findings of operation: Strangulated Hernia

of autopsy: Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Houck L. Bolton M.D.
Address Balt. City Hosp. Date signed 3/1/45

26466
469755

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1579

Registered No. 26466

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 N Wolfe Calhoun St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Loloise Malary.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-23-45

8. AGE: Years | Months | Days 7 | If less than one day .....hr. .....min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER
12. Name Loloise Malary.
13. Birthplace N.C.

MOTHER
14. Maiden Name Elizabeth Allen
15. Birthplace N.C.

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3-3rd 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto. Co. Md.

18 (a) Funeral director Belmont Maynard & Vaughn
(b) Address 727 Eutaw St.

19 (a) MAR 3 - 1945 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1945, at 2.30 PM A

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26 1945 to March 2 1945 and that I last saw him alive on March 2 1945

Immediate cause of death	Duration
Operation, repair of	
Due to esophageal atresia with tracheo-esophageal fistula	
Due to	
Other Conditions prematurity, cleft palate (Include pregnancy within 3 months of death)	

Date of operation 3-1-45
Major findings of operation: see above
of autopsy: not reported

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at .....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature John R. Birmingham M.D.
Address JHH Date signed 3-4-45

VS 180

G26467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G26467 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the caubes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4523 Furley Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Leonard Knipp

3 (b) If veteran, name war.....
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 8, 1929

8. AGE: Years 15 | Months 7 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Edwin Knipp.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Eunice Mushilly
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Edwin F. Knipp
(b) Address 4523 Furley Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Mar. 6, 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto., Md.

18 (a) Funeral director Lazarus Funeral Home
(b) Address 7401 Belair Road

19 MAR 3 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1945 at 5:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 19 1945 to March 1 1945 and that I last saw him alive on March 1 1945

Immediate cause of death	Duration
Medullary failure	
Due to Tuberculous Meningitis	10 days+
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury.....

23. Signature Roy Byron Burner, Jr. M.D.
Address Mercy Hospital Date signed 3/1/45

X

G26468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G26468

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2500 Browning Highway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 18yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 833 Poplar Grove St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Kreitzburg
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1889

8. AGE: Years 55 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Electrical Tester
11. Industry or business Western Electric Co.

FATHER
12. Name Henry Kreitzburg
13. Birthplace Md.

MOTHER
14. Maiden Name Theresa Ratigan
15. Birthplace Md.

16 (a) Informant Miss Anna M. Kreitzburg
(b) Address 833 Poplar Grove St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3400 Old Frederick Rd

18 (a) Funeral director Harry H. Writzler
(b) Address 4101 Edmondson Ave

19 (a) Date received by registrar APR 3 1945 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-1- 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death	Duration
Coronary Thrombosis	
Acute Myocarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. H. Andrews M. D.
Address 5410 Willowmere Rd. Date signed 3-1-45

Attest, Howard J. Andrews per Edw D. Furgeson Felice D. Mugrad R.N.

626469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

626469 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 814 Powers Street
(c) Hospital or institution:

12-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 814 Powers Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Lillie A. Marsden

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife William H. Marsden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9-1872

8. **AGE:** Years 72 | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace Laurel, Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Horace E. Jones
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie L. Sullivan
15. Birthplace Maryland

16 (a) Informant Miss Elsie E. Marsden
(b) Address 814 Powers Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5-1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

MAR 3 - 1945 (Date rec'd by Registrar) Huntington Williams Md. Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** March 2- 1945, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1945 to Mar 2 1945, and that I last saw her alive on Mar 1 1945.

Immediate cause of death — Cerebral Hemorrhage — Duration sudden

Due to Cardio-vascular disease — 5 yrs.

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ivan Sullivan

Address 5460 W 36th St. Date signed 3/3/45

VS 190

G26470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G26470 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 810 E. 37th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 810 E. 37th Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Frederick Apt

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-18-4102

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Lillie M. Apt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21-1871

8. AGE: Years 73 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Guard - Johns Hopkins Hosp.

11. Industry or business

FATHER
12. Name Martin L. Apt
13. Birthplace Germany

MOTHER
14. Maiden Name Fredericka Eberle
15. Birthplace Germany

16 (a) Informant Chester L. Apt.
(b) Address 4026 Hickory Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5-1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road
Huntington Williams, M.D.

MAR 2 - 1945 (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1945, at 6:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to Mar 1 1945, and that I last saw him alive on Feb 18 1945.

Immediate cause of death: Coronary Thrombosis — Duration: Mins.

Due to Arteriosclerosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm N. McFaul Jr.
Address 1800 N. Charles St. Date signed 3/1/45 M. D.

X

G26471

Scheff

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G26471 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 N Mont Ford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 N Mont Ford (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George J LeCleff

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Widower

6 (b) Name of husband or wife Phillippine LeCleff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 2 1874

8. AGE: Years	Months	Days	If less than one day
70	3	11	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business Box Maker

FATHER 12. Name Henry LeCleff

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Meyers

15. Birthplace Germany

16 (a) Informant Margaret E Kidd

(b) Address 2610 Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/45 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Colgate Md

18 (a) Funeral director Pollock Funeral Home

(b) Address 2006 Pulaski St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MAR 3 - 1945 VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1945, at 2 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16th 1945, to March 2 1945, and that I last saw h~~e~~r alive on March 2 1945.

Immediate cause of death	Duration
Cardio Vascular disease	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Tankersley M. D.

Address 100 N Miller ay Date signed 3/3/45

X

G26472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

Registered No. G26472

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3415 Clarks Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 120

(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3415 Clarks Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Tinie F. Goldstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~or wife~~ Edward C. Goldstein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1862

8. AGE: Years 82 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Phila. Pa. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Bernard H. Feustman,
13. Birthplace Germany

MOTHER
14. Maiden name Rosalia Mayer,
15. Birthplace Germany

16 (a) Informant Mrs. Irving Cohn,
(b) Address 3415 Clarks Lane

17. (a) Removal (b) Date thereof 3/4/45 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery ~~or crematory~~ Mt. Sinai
Location Phila. Pa.

18 (a) Funeral director David Sondheim & Son
(b) Address 1940 Eutaw Place

19. MAR 3 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1945, at 8:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1937 to Mar 1945. that I last saw her alive on March 1945.

	Duration
Immediate cause of death: Cerebral Thrombosis	4 weeks
Due to: Arteriosclerosis	7 years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan Bernstein M. D.
Address 1039 N Calvert St Date signed 3/4/45

BOUYER

G26473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 154B

Registered No. G26473

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calhoun & Franklin Sts

(c) Hospital or institution: Franklin Sq. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 7 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 3206 Hanlon Pk. Rd. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Wm. Bouyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Christine

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8-8-1874

8. AGE: Years 70 Months 6 Mos Days 24 If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER

12. Name Frazelers Bouyer

13. Birthplace Md.

14. Maiden Name Jane Green

15. Birthplace Md

16 (a) Informant Wife

(b) Address 3206 Hanlon Pk. Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-45 (month) (day) (year)

(c) Cemetery or crematory Mayotte Cemetery

Location A. A. County Md

18 (a) Funeral director Williams & Jackson

(b) Address 916 Pennsylvania ave

19 (a) MAR 3 - 1945 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2 1945 at 4:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/6 1945 to 3/2 1945

and that I last saw h[illegible] alive on 3/2 1945

Immediate cause of death Septicemia

bacterial endocarditis

Due to

Due to

Other Conditions Osteomyelitis of R knee

(Include pregnancy within 3 months of death)

Date of operation 1/13/45 Amputation

Major findings of operation: knee joint & profound

of autopsy: See cause of death.

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Carl Myers

Address Franklin Sq. Hosp. Date signed 3/2/45 M. D.

910

VS 150

G66474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G66474

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1029 Booth St
(c) Hospital or institution: 18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 Booth St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Jennie Johnson Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1900

8. AGE: Years	Months	Days	If less than one day
44	8	27	hr. min.

9. Birthplace Annapolis, Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Jennie J. Brown
(b) Address 1029 Booth St.

17 (a) Burial (b) Date thereof March 3, '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 MAR 3 1945 (b) Huntington Williams, M.D.
(Date rec'd by Reg.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1945 at 10:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1945 to Feb 27 1945 and that I last saw him alive on Feb 25 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 4 days
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John W. Gaines
Address 665 W. Barre St. Date signed 3/3/45

G26475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 51 B

Registered No. G26475

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1931 E. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Lyles.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: married.
6 (b) Name of husband or wife: Annie Lyles.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/30/1884

8. AGE: Years 60 | Months 8 | Days 2 | If less than one day: hr. min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Lyles.
13. Birthplace S. C.

MOTHER
14. Maiden Name Anna Borkman
15. Birthplace S. C.

16 (a) Informant Wendo.
(b) Address

17 (a) Removal (b) Date thereof 3/3/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Columbia, S. C.
Location Joseph D. Locke
18 (a) Funeral director
(b) Address 1304 N. Central Ave
19 (a) Date received by local registrar MAR 3 1945 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2 1945 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 1945 to 3-2 1945 and that I last saw him alive on 3-2 1945

Immediate cause of death Cardiac failure — Duration 24 hrs

Due to Carcinoma of prostate & Carcinoma of bladder — Duration one yr.

Due to — Duration

Other Conditions Generalized arterio-sclerosis & hypertension — Duration over 1 yr.
(Include pregnancy within 3 months of death)

Date of operation 3/1/45

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edw. J. Rabendeau, Jr. M.D.
Address Johns Hopkins Hosp. Date signed 3/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

666476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. 666476

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital. 27+
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13da
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5012 Harford Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Fulton B. Turner ✓

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mrs. Elma [illegible] Turner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1889

8. AGE: Years 55 | Months 10 | Days 28/29 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Repair Man
11. Industry or business Telephone Co.

FATHER
12. Name James H. Turner
13. Birthplace Virginia

MOTHER
14. Maiden Name Sarah Wellons
15. Birthplace Maryland

16 (a) Informant Mrs. Elmay B. Turner
(b) Address 5012 Harford Road

17 (a) Burial (b) Date thereof 3-6-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Bally Methodist Cem
Location Balt

18 (a) Funeral director Leonard Pluck
(b) Address MAR 3 1945 Harford Road

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3/45 19 at 3:37 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17/45 19 to 3/3/45 19, and that I last saw h[illegible] alive on 3/3/45 19.

Immediate cause of death	Duration
Respiratory failure	
Due to Labor pneumonia	4 days
Due to operation for carcinoma of Rectum.	
Other conditions Cardiac decompensate Hypertension C.V. disease	

(Include pregnancy within 3 months of death)

Date of operation 2/25/45
Major findings of operation: carcinoma of rectum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C.F. Hobelmann
Address Mercy Hospital Date signed 3/3/45 M D

C-F. Hobelmann

G26477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G26477

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1405 E. Federal St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 E. Federal St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Wildberger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sophie E. Jasik

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) June 26, 1896

8. AGE: Years 48 | Months 8 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Jewel Tea Co.

FATHER 12. Name Henry Wildberger

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Louise Glatzel

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Sophie E. Wildberger

(b) Address 1405 E. Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-45 (month) (day) (year)

(c) Cemetery or crematory All Faith Cem.

Location Baltimore Co. Md.

18 (a) Funeral director Leonard J. Burke

(b) Address 6305 Harford Rd.

19 (a) MAR 3 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28 1945 at 10a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1944 to 2/28 1945 and that I last saw h. alive on 2/26 1945

Immediate cause of death	Duration
Carcinoma of Colon.	2 years
Pulmonary metastasis -	
Due to Polyposis of Colon.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sol Smith M. D.

Address 1223 E. North Date signed 2/2/45

X

626478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a ✓

Registered No. 626478

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dim.
(e) Length of stay in Baltimore (yrs., mos., or days) 7yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 945 Montpelier St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Hunt

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 298 10 6608

4. Sex: M

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Anna M. Hunt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 30 1890

8. AGE: Years 54 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation Guard - Bethelhem Steel

11. Industry or business

FATHER
12. Name Jacob W. Hunt
13. Birthplace N.J.

MOTHER
14. Maiden Name Mary Weeks
15. Birthplace N.J.

16 (a) Informant ANNA M. HUNT (WIFE)
(b) Address 948 MONTPELIER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 5/45 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly & Zollickoffer
(b) 93 S. WOLFE ST.

19 (a) MAR 6 1945 (Date rec'd by registrar) (b) Huntington Williams, Mar. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1945, at 12:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1945, to March 2 1945, and that I last saw him alive on March 2 1945.

Immediate cause of death	Duration
(a) Cardiac Failure	
Due to (b) Coronary Thrombosis	7 hrs.
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Roy Bynum Turner, M. D.
Address Mercy Hospital Date signed 3/2/45

VS 130

X

626479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered 626479

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 218 S. WOLFE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 218 S. WOLFE ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Jacob Sigwart

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Mamie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/18/80

8. AGE: Years 64 | Months 4 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Theodore Sigwart
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Balto., Md.

16 (a) Informant Mamie Sigwart (wife)
(b) Address 218 S. WOLFE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 5/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director [illegible]
(b) Address 403 S. WOLFE ST.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

VS 150 MAR 7 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 1 1945, at 8/10 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1945, to Mar 1 1945, and that I last saw him alive on Mar. 1 1945.

Immediate cause of death	Duration
Pulmonary Edema	10 days
Due to Chronic myocarditis	years
Due to Cirrhosis of liver	years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George D. Lilly M. D.
Address 432 S. Patterson Pk. Date signed 3/7/45

G26480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G26480 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 W Lombard (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Zinkler

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife. George C. Zinkler
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) February 13, 1888

8. AGE: Years	Months	Days	If less than one day
57	—	17	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm Landmore
13. Birthplace Balto

MOTHER
14. Maiden Name Elizabeth Nagel
15. Birthplace Balto

16 (a) Informant George C. Zinkler
(b) Address 1819 W Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director George W. Schwab
(b) Address 2101 Frederick Avenue

19 (a) MAR 5 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2 1945, at 8:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28 1945, to 3-2 1945, and that I last saw her alive on 3-2-45 1945

Immediate cause of death Peritonitis — Duration

Due to Perforated Colon

Due to Carcinoma of colon

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. K. Kezerian, M. D.
Address Franklin Square Hospital Date signed 3-2-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G26481

~~G26481~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3711 Forest Park Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Castleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Nathan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 63 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Yaron Chirodel
13. Birthplace Russia

MOTHER
14. Maiden Name Belle
15. Birthplace Russia

16 (a) Informant Nathan Castleman
(b) Address 3711 Forest Park Avenue

17 (a) Burial (b) Date thereof Mar. 2, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Helen Young Mem
Location Windsor Mill Road

18 (a) Funeral director Sol Riverson & Bros
(b) Address 424-26 W North ave

19 4-1945 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1945, at 4:30 P. M

21. I certify that I took charge of the remains described above, held an ..... thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary Edema. Fracture of Left lower leg.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-10-45 at 7:30 P. M.
(b) Where did injury occur Forest Park & Ayndale Ave
(c) Did injury occur at home, on farm, industrial place, in public place Public. While at work? no.
(d) Means of injury Pedestrian struck by Auto

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 3, 1945.

VS 151

...correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 626482

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1654 N Bentalou St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1654 N Bentalou St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Pearl Klavan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Sol H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Harrisburg Pa
(Town, county, and state)

10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Julius Kanter
13. Birthplace Lith

MOTHER
14. Maiden Name Mary Rosenberg
15. Birthplace Lith

16 (a) Informant Sol H Klavan
(b) Address 1654 N Bentalou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 4 1945 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MAR 4 - 1945

MEDICAL CERTIFICATION 6.30

20. DATE OF DEATH March 2, 1945, at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1941 to March 1945, and that I last saw h alive on March 1945:

Immediate cause of death Lymphosarcoma — Duration

Due to Primary in Lung.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Meade M.D.
Address 314 W. North Ave Date signed 3/2/45

X

626483

BALTIMORE CITY HEALTH DEPARTMENT ✓ 626483

Registered No.

CERTIFICATE OF DEATH 13

Jo #88078

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos. 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie L Club

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife George (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1892

8. AGE: Years	Months	Days	If less than one day
62	-2-	15	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Hawk
11. Industry or business

FATHER
12. Name Daniel J. (d)
13. Birthplace ?

MOTHER
14. Maiden Name Mary McCormick (d)
15. Birthplace ? Unable to obtain information

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 3/4/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director [signature]
(b) Address 1318 Light St

MAR 7 - 1945 (b) Livingston Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28, 1945, at 9:45P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 18, 1944, to Feb. 28, 1945, and that I last saw her alive on Feb. 28, 1945.

Immediate cause of death	Duration
Heart failure	days
Due to Pulmonary Tuberculosis (T)	
Due to	months
Other Conditions Chronic nephritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Baltimore City Hosp. Date signed 3/3/45

G26484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

G26484 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A
(b) Street address Cleveland and Charles St - Belvedere Hotel
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 St. Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME May Louise Frick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	

6 (b) Name of husband or wife Frederick W. Frick
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) July 15 1902

8. AGE: Years	Months	Days	If less than one day
42	7	16	hr. min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name George Cooper Dean
13. Birthplace Roxbury Conn

MOTHER
14. Maiden Name May Smith
15. Birthplace Washington D.C.

16 (a) Informant Frederick W. Frick
(b) Address 817 St Paul St

17 (a) Removal (b) Date thereof Feb 5 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Maplewood
Location Patterson Putnam Co N.Y.

18 (a) Funeral director Henry W. Jackson Inc
(b) Address 3 E. Cullen St Orchard Bldg Baltimore, Md.

MAR 4 - 1945 (Date rec'd by registrar)

(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3 1945, at 12:24 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wound of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/3/45 about 12:00 Noon
(b) Where did injury occur? Belvedere Hotel - Room 930
(c) Did injury occur at home, on farm, industrial place, in public place? Hotel While at work? No
Self inflicted with 38.
(d) Means of injury Caliber Pistol

23. Signature C. J. Pelzinski M.D. Medical Examiner.
Date signed 3/3/45

VS 151

G26485 BALTIMORE CITY HEALTH DEPARTMENT X ✓G26485
CERTIFICATE OF DEATH 50 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette St & John
(c) Hospital or institution Women's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43d
(e) Length of stay in Baltimore (yrs., mos., or days) 43d

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Somerset
(c) City or town Princess Anne
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS ETHELINDE DENNIS OATES

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Rev Luther A Oates
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 31 - 1876

8. AGE: Years 68 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace Worcester Somerset Co Md.
(Town, county and state)

10. Usual Occupation Librarian
11. Industry or business

FATHER
12. Name Samuel K Dennis
13. Birthplace Worcester Co Md

MOTHER
14. Maiden Name Sally Handy
15. Birthplace Crisfield

16 (a) Informant Mabel S. Oates
(b) Address 613 Register ave.

17 (a) Interment Presbyterian (b) Date thereof Mar 3 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Presbyterian
Location Princess Anne Md

18 (a) Funeral director Henry N Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) 1945 (b) Walter Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 March 1945, at 11.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Jan 1945 to 2 Mar 1945; and that I last saw h[illegible] alive on 2 Mar 1945.

Immediate cause of death Carcinomatosis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: generalized Carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Felix Rutledge M. D.
Address Womens Hospital signed 3/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important.

626436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

626436 Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3730 E. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rose E. Joyce

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband or wife: John J. Joyce
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9th 1885

8. AGE: Years 59 | Months 8 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Hugh Priesty
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Daley
15. Birthplace Ireland

16 (a) Informant John J. Joyce
(b) Address 3730 E. Lombard St

17 (a) Burial (b) Date thereof 3/6/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

(a) APR 4 - 1945 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3 1945, at 12:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1944, to 3-3 1945; and that I last saw h~~er~~ alive on March 2 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 Months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. J. Davidow M. D.
Address 3268 Eastern Date signed 3-3-45

626487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13/a

626487 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 Westwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3025 Westwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emely P Colson

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Monk
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 13. 1867
8. AGE: Years 78 | Months 0 | Days 19 | If less than one day hr. min.
9. Birthplace Calvert Co Md (Town, county, and State)
10. Usual Occupation Housework
11. Industry or business

MOTHER / FATHER
12. Name James Dixon
13. Birthplace Md
14. Maiden Name Annie Hardesty
15. Birthplace Md

16 (a) Informant Lloyd D Colson
(b) Address 3025 Westwood Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md
18 (a) Funeral director Milburn Bros Inc
(b) Address 2104 Gold St
19 (a) 3-1945 (b) (Date rec'd by registrar) Huntington Williams By Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1945, at 1 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1945 to Mch 2 1945
and that I last saw h[illegible] alive on Mch 1 1945

Immediate cause of death: Chronic Cardio Renal disease — Duration: 7
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Lloyd D Colson
Address 1732 Pop. Ave Date signed 3/2/45

VS 150

X

626488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 a

626488

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1031 N. Fulton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1031 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie V. Armfield

3 (b) If veteran, name war W.
3 (c) Social Security Account No. none

4. Sex Female
5. Color or race White
6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married
6 (b) Name of husband Thomas M. Armfield
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 3rd 1870
8. AGE: Years 74 Months 8 Days 0 If less than one day hr. min.
9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Flynt
13. Birthplace N. C.

MOTHER
14. Maiden Name Matilda Walker
15. Birthplace N. C

16 (a) Informant Mrs Lillian Pyle
Address 68 Balto. Blvd. College Park Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ London Park
Location Balto, Md
18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St
19 (a) 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 3rd 1945, at 12 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3 1945, to 3/3 1945, and that I last saw her alive on 3/4 1945.

Immediate cause of death Cardiac failure — Duration
Due to Uremia
Due to Chronic glomerulo-nephritis
Other Conditions Generalized arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature I. Shadgen
Address 6010 Branch Ave Date signed 3/5/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G26489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G26489 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4135 FAIRVIEW AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 10 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town 4135 FAIRVIEW AVE (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA ZELLER MAYER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: DAVID

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace ROUMANIA (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ISRAEL

13. Birthplace ROUMANIA

MOTHER 14. Maiden Name SURE

15. Birthplace ROUMANIA

16 (a) Informant FAMILY RECORDS

(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-4-45 (month) (day) (year)

(c) Cemetery or crematory MT CARMEL

Location J'DONNEL ST

18 (a) Funeral director JACK LEWIS INC

(b) Address 1439 E. BALTO ST.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

MAR 4 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-3-45 19 , at 4.15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 1945 to March 3 1945, and that I last saw h[er] alive on March 2 1945

Immediate cause of death: Pulmonary Embolism — Duration: minutes

Due to Cardiac Hypertrophy — 10 yrs

Due to Chronic Bronchitis with Asthma — 2 weeks

Other Conditions — 10 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide no

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Joseph H Zeller M.D.

Address 2318 Eutaw Place Date signed 3/3/45

G26490

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G26490 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 2424 E. Biddle St.
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Edward F. Holland

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Elizabeth Holland
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) April 17, 1881

8. AGE: Years	Months	Days	If less than one day
63	11	14	..... hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Station Engineer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Elizabeth Holland
(b) Address 2424 East Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East North Ave

18 (a) Funeral director S. Walter Mayo
(b) Address 619 N. Broadway St.

MAR 4 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1945, at 11:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic lymphosarcoma of Leptomeninges

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Mackenzie M.D.
Medical Examiner.
Date signed 3-3-45

VS 151

G26491 G26491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 E. 36th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 51 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 E. 36th Street
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Norman Vincent Waltjen, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Keller
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1893

8. AGE: Years	Months	Days	If less than one day
51	5	24	-- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Adjuster
11. Industry or business U. S. Fidelity & Guar

FATHER
12. Name Walter F. Waltjen
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Martin
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Mary M. K. B. Waltjen
(b) Address 1014 E. 36th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

MAR 4 - 1945 Huntingtown Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 2 1945, at 9.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1945, to Mar 2 1945, and that I last saw h. alive on Mar 2 1945.

Immediate cause of death	Duration
Coronary thrombosis	5 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Lee Thurber M.D.
Address 4416 Northern Parkway Date signed 3/3/45 M. D.

VS 150

G26492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87c

G26492 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1832 W. Fayette Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 69 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1832 W. Fayette Street (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Cecilia Agnes O'Neill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William O'Neill
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1876

8. AGE: Years	Months	Days	If less than one day
69	1	20	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Timothy Ryan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Shortal
15. Birthplace Ireland

16 (a) Informant Richard O'Neill
(b) Address 1832 W. Fayette Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. V. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) ---------- (Date received by registrar) (b) ---------- Registrar

MAR 4 1945 Funeral to Williams, Inc.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1945, at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1944 to March 2 1945, and that I last saw h[illegible] alive on March 2 1945

Immediate cause of death: Pulmonary Congestion — Duration: 2 hrs
Due to: Acute Edema — Duration: 2 hrs
Due to: ---------- — Duration: ----------
Other Conditions: ----------

(Include pregnancy within 3 months of death)
Date of operation ----------
Major findings of operation: ----------
of autopsy: ----------

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ----------
(b) Date of occurrence ---------- at ---------- M
(c) Where did injury occur? ---------- (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ---------- While at work? ---------- (Specify type of place)
(e) Means of injury ----------

23. Signature W. S. Gray
Address 6 W. Madison St. Date signed March 2 1945

X

G26493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G26493 46E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4015 Liberty Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Granite (If outside city or town limits, write RURAL and give town)
(d) Street No. Dans Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary B Dennis

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Joseph Dennis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-29-1875

8. AGE: Years	Months	Days	If less than one day
69	8	4	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Joseph Stamm
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Horn
15. Birthplace Germany

16 (a) Informant Joseph Dennis
(b) Address Granite Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-45 (month) (day) (year)
(c) Cemetery or crematory St Alphonsus
Location Woodstock Md

18 (a) Funeral director F.C. Nuguhotton
(b) Address Ellicott City Md

19 (a) 1945 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7 1945 at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 19-45 to 2-7 19-45. and that I last saw h[illegible] alive on 2-7 19-45.

Immediate cause of death Coronary Occlusion

Due to

Due to

Other Conditions Old age

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: no

Duration: 1 yr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

X 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26494

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G26494
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8 Club Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Club Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Cookman Boyd

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Hallie A. Boyd
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Dec. 13, 1866
8. AGE: Years 78 | Months 2 | Days 20 | If less than one day hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Lawyer
11. Industry or business

FATHER
12. Name: Wm. H. Boyd
13. Birthplace: Frederick Co., Md.

MOTHER
14. Maiden Name: Sarah E. Jackson
15. Birthplace: Balto., Md.

16 (a) Informant: Mr. J. Cookman Boyd, Jr.
(b) Address: 105 Taplow Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/45 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville, Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 MAR 4 - 1945 (Date received by registrar) (b) Huntingtor Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3 1945, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/16 1945 to 3/3 1945, and that I last saw h[illegible] alive on 3/1 1945.

Immediate cause of death	Duration
Cerebral thrombosis +	2 d.
Cardiac failure	1 mo.
Due to Arteriosclerotic cardio-vascular disease.	yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Edward Leach
Address 14 E. Eager St. Date signed M 3 D 3/4/45

X

626495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

626495 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 115 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: CATHERINE C. DIENHART

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Frederick E. Dienhart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 6, 1893

8. AGE: Years	Months	Days	If less than one day
51	5	25	hr. min.

9. Birthplace: Howard Co., Md.
(Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Thomas John Mulchy
13. Birthplace: ~~Ireland~~ Virginia

MOTHER
14. Maiden Name: ~~Same~~ Mary Hughes
15. Birthplace: Md.

16. (a) Informant: Mr. Frederick E. Dienhart
(b) Address: 115 N. Fulton Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18. (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

MAR 4 - 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1945, at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from February 1945 to March 1945, and that I last saw her alive on March 1st 1945.

Immediate cause of death: Atypical carcinoma of labia, advanced.
Due to:
Due to:
Other Conditions: Ascites, pneumonia
(Include pregnancy within 3 months of death)

Date of operation: Jan 1945
Major findings of operation: Atypical carcinoma of labia.
of autopsy:

Duration
3 months from history and physical examination

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: E. J. Pangle
Address: 1226 Hanover St Date signed: 3-4-45 M. D.

VS 150

G26496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G26496 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 S. Franklintown Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 S. Franklintown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christian Beck

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 28-1867

8. AGE: Years	Months	Days	If less than one day
77	11	3	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Adam Beck
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta Krentzer
15. Birthplace Germany

16 (a) Informant Anna Beck
(b) Address 104 S. Franklintown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director F. J. Keppert Son
(b) Address 856 W. Baltimore St

MAR 4 - 1945 (a) (Date filed by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 1st 1945, at 6:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1-15 1945, to Mar 1st 1945 and that I last saw him alive on 2-28 1945.

Immediate cause of death Arteriosclerosis of brain — Duration 18 mos.
Due to General arteriosclerosis — 3 yrs.
Due to Edema of brain — 3 yrs
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Peck
Address 2702 Brookfield Ave Date signed 3-3-45 M. D.

VS 150

K 264367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G26497 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 10 -10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2793 Wilkins Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Jessop

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1889

8. AGE: Years	Months	Days	If less than one day
55	11	13	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name John Jessop.
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Selle
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 6/45 (month, day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director J. J. Wagner & Son
(b) Address 130 Eutaw Place

MAR 4 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1945, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1942 to Mar. 2 1945, and that I last saw her alive on March 2 1945.

Immediate cause of death	Duration
Rupture metastatic nodule in liver & hemoperitoneum	1 day
Due to Carcinoma of colon and prostate with metastases	?
Due to to liver	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospitals Date signed 3-3-45

VS 150

626498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

626498 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2234 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2234 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Buchanan

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife George A. C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1864

8. AGE: Years 80 81 | Months 5 — | Days — 17 | If less than one day hr. min.

9. Birthplace Anne Arundel Co. Md. (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Rachael Downs

15. Birthplace Anne Arundel Co. Md.

16 (a) Informant Lillie A. Buchanan

(b) Address 2234 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-1945 (month) (day) (year)

(c) Cemetery or crematory Arbutus

Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George A. Stallard

(b) Address 163 Druid Hill Ave

19 (a) (Date received by registrar) (b) Registrar

MAR 4 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2- 1945, at 4:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1- 1945, to 3-2- 1945, and that I last saw her alive on 2-26- 1945.

Immediate cause of death	Duration
Arteriosclerosis	
Due to Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Findings of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell M. D.

Address 718 Dolphin St. Date signed 3-4-45

X

626499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

626499 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 Richmond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 Richmond St
(If rural give location)
(e) Citizen of foreign country? W (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Deery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/1-1867

8. AGE: Years	Months	Days	If less than one day, hr.	min.
67	3	0	18	7

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Patrick Deery
13. Birthplace Ireland

MOTHER 14. Maiden Name Ellen M Sneed
15. Birthplace Balto Co. Md

16 (a) Informant Margaret L Dickman
(b) Address 216 Dickman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Flynn
(b) Address 1426 Light St.

19 (a) (Date rec'd by Local Reg.) (b) Registered No.

MAR 4 1945

Hunterstown Hilltop

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1945, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1945, to March 1 1945, and that I last saw h[illegible] alive on March 1 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 da.
Due to arteriosclerosis & chronic nephritis	
Due to Fractured arm	7 da. 2/26/45
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 23
(a) Accident, suicide, or homicide accident Falling
(b) Date of occurrence Morning of Feb 26 1945 at 11 A.M.
(c) Where did injury occur? at home
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work?
(Specify type of place)
(e) Means of injury Fell to floor

23. Signature Howard L Dickman M.D.
Address 164 E Lanvale St Date signed 3/2/45

Above - Howard L Dickman, M.D.

626500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

626500 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2939 Mc Elderry st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3000 E. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Edith L. Wildason

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-12-9174

4. Sex: Fmal | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Wm A. Wildason

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27-1887

8. AGE: Years 57 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Press Operator

11. Industry or business Federal Sign Co.

FATHER
12. Name E. Rapp
13. Birthplace ?

MOTHER
14. Maiden Name — ? Smith
15. Birthplace

16 (a) Informant Wm A. Wildason
(b) Address 3000 E. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 5 45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore

18 (a) Funeral director Philip Herwig Sons
(b) Address 2524 Orleans St

19 (a) Filed [illegible] 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 1 1945, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1944 to Jan 1 1945 and that I last saw h alive on Jan 1 1945.

Immediate cause of death Coronary Thrombosis. Duration 4 mos.

Due to

Due to

Other Conditions Arteriosclerosis. 7

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allen E. Sikorski M.D.
Address 2939 Mc Elderry St Date signed 3/6/45

626501 626501

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 186 a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: Balto. Md, St. Jaughs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (14) Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Louise Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles J. Schreiber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife Clara V Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20-1871

8. AGE: Years 74 Months 1 Days 11 If less than one day hr. min.

9. Birthplace Balt. Md.
(Town, county, and state)

10. Usual Occupation Retired Title Setter

11. Industry or business

FATHER 12. Name Philip Schreiber
13. Birthplace Germany

MOTHER 14. Maiden Name Catherine
15. Birthplace Germany

16 (a) Informant Mrs Margaret Taylor.
(b) Address 3008 Louise Ave.

17 (a) Burial (b) Date thereof 3-7-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balto Md.

18 (a) Funeral director Leonard J. Burch.
(b) Address 5304 Harford Rd.

19 (a) 3-5-1945 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1945 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27 1945, to March 3 1945, and that I last saw him alive on March 3 1945

Immediate cause of death	Duration
Congestive Failure	
Due to Chronic Myocardial Degeneration	
Due to	
Other Conditions Fractured Rt. Hip	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Feb 27 at 12:30 P M
(c) Where did injury occur? Hamilton (City or town) 14 (County) Balto Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? No
(e) Means of injury Fall down cellar steps

23. Signature A. M. Bacon Jr. M. D.
Address St Josephs Hospital Date signed 3-3-45

Approved: J. R. Davis M.D. Registrar Baltimore

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 626502

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33[illegible] Calvert St.

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (~~yrs., mos., or days~~) 2

(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 3

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 636 Dunkirk Rd. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Charles Reginald Holtzman, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: 0

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1941

8. AGE: Years 3 | Months 4 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation 0

11. Industry or business 0

FATHER

12. Name Charles R. Holtzman, Sr.

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Barbara Elizabeth Fink

15. Birthplace Hamilton, Ontario, Canada

16 (a) Informant Mrs. Chas. R. Holtzman

(b) Address 636 Dunkirk Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location

18 (a) Funeral director L. J. Rzucki

(b) Address 5306 Harford Rd.

MAR 5 - 1945 (Date rec'd by Registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1945 at 1 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 2 1945 to Mar. 4 1945 and that I last saw him alive on Mar. 4 1945

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Vascular Accident	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Melchiade Gregoire M.D.

Address U. M. H. Date signed 3-4-45

VS 150

626503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

Registered No. 626503

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Graham St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State California (b) County
(c) City or town San Francisco
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2120 California St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lily B. Graham

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Smart.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10 1882

8. AGE: Years	Months	Days	If less than one day: hr.	min.
62	7	24		

9. Birthplace London England
(Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edwin Tolfrye
13. Birthplace England

MOTHER
14. Maiden Name Susan (Unknown)
15. Birthplace England

16 (a) Informant Mrs. Lily Gotcheon
(b) Address Arlington Va

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 3/6/45 (month) (day) (year)
(c) Cemetery or crematory Washington
Location Washington D C

18 (a) Funeral director W. H. Thomber Co
(b) Address Washington D C

19 MAR 5 - 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-4 1945, at 2.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2 1945 to 3-4 1945, and that I last saw h~~er~~ alive on 3-4 1945.

Immediate cause of death ~~Hypostatic pneumonia~~ Status asthmaticus — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Josephs Hosp Date signed 3-4-45

G66504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G66504

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2260 Brookfield Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) ~~City~~ or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2260 Brookfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Heller Wenk

3 (b) If veteran, name war: W

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband or wife: Edward Wenk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 21st 1877

8. AGE: Years 67 | Months 11 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name August Heller
13. Birthplace Germany

MOTHER
14. Maiden Name Lena Rosenthal
15. Birthplace Pa.

16 (a) Informant Edward Wenk Jr
2260 McKay Circle - Bethesda Md

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 3/5/45 (month) (day) (year)
(c) Cemetery or Crematory Mt Sinai Cemetery
Location Balto. Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) ... (b) ... Registrar
(Date rec'd by registrar)
MAR 5 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 3rd 1945, at 6 40 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1944 to Mar 3 1945 and that I last saw h[er] alive on Mar 2d 1945

Immediate cause of death	Duration
Lymphosarcoma	10 mos
Due to	
Due to	
Other Conditions Acute pulmonary edema - Arteriosclerotic heart	1 day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Enlarged mediastinal glands enlarged glands around abdominal aorta; splenomegaly

Autopsy? Yes

22. If death was due to external causes (violence) fill in the following: Inquest would be reported

(a) Accident, suicide or homicide?

(b) Date of occurrence Later (Johns Hopkins Hosp) M

(c) Where did injury occur? Path Dept
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Louis P. Hamburger M. D.

Address 1207 Eutaw Pl Date signed 3-3-45

PHYSICIAN
Underline the cause to which death should be charged statistically.

626505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

626505 Registered No. V 178a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-0-4
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Eutaw Place
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Margaret Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. 4

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 22nd 1913

8. AGE: Years 31 | Months 2 | Days 10 | If less than one day .....hr. .....min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Waitress

11. Industry or business Toots Denelle Cole

FATHER
12. Name John T. Hayes
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ellen Clinton
15. Birthplace Ireland

16 (a) Informant John T. Hayes
(b) Address 543 Hillsdale Court

17 (a) Burial (b) Date thereof 3/6/45
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Mary's
Location Govans-Baltimore Md

18 (a) Funeral director Wilhelm Bros & Son
(b) Address 1211 E Fort Ave

19 (a) MAR 5 - 1945 (b) Baltimore Md
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2- 1945 at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ or suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating Gas

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-2-45 at ..... P. M.
(b) Where did injury occur? 101 E. 29th Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Unlit gas stove jets.

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 3-3-45

626506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 626506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1109 N. Gilmore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 N. Gilmore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard W. Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Hortense Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1902

8. AGE: Years 42 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John W. Johnson
13. Birthplace md.

MOTHER
14. Maiden Name Laura Hughes
15. Birthplace md.

16 (a) Informant Hortense Johnson
(b) Address 1109 N. Gilmore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brantley Ave

MAR 5 - 1945 (Date rec'd by Local Reg.)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 1945 at 4 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1945 to Feb 1 1945 and that I last saw h[illegible] alive on Feb 1 1945

Immediate cause of death Cerebral Apoplexy

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 3 hrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. T. Hatcher

Address 1 W Preston Date signed 2/3/45

VS 150

626507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

626507 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 556 Wilson st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 556 Wilson st
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Howard West

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife: Amelia West
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Cape Charles, Va.
(Town, county, and state)

10. Usual Occupation unemployed.
11. Industry or business

FATHER 12. Name John Henry West
13. Birthplace Va.

MOTHER 14. Maiden Name Addie ?,
15. Birthplace Va.

16 (a) Informant Margaret Murray
(b) Address 556 Wilson st

17 (a) Burial (b) Date thereof Mar 5 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 - Brantley av

19 (a) MAR 5 - 1945 (b) Huntington Wilkins Registrar
(Date rec'd by registrar)

VS 150

3/1/45 **MEDICAL CERTIFICATION** 7 P.M.

20. DATE OF DEATH: March 1 1945 at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to March 1 1945 and that I last saw him alive on March 1 1945

Immediate cause of death	Duration
Condro-Nasonla disease	1 year?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Watts, M.D.
Address 515 Gilmor Date signed 3/3/45

G26508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1940

Registered No. G26508

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 624 N. Milton Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Howard Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna Teresa Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29-1874

8. AGE: Years 70 | Months 2 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Lawrence Johnson
13. Birthplace Denmark

MOTHER
14. Maiden Name Mary E. Pettis
15. Birthplace Md.

16 (a) Informant Anna Teresa Johnson
(b) Address 624 N. Milton Ave.

17 (a) Burial (b) Date thereof Mar. 5-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cath. Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director John L. Miller
(b) Address 2334 Jefferson St.

19 MAR 5 - 1945 Christopher Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1945, at 11:01 A.M.

21. I certify that I took charge of the remains described above, held an Inquest & Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ..... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 3-2-45

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

626509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

626509
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 W. Lanvale St.
(c) Hospital or institution: St. Joseph's Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County Balto.
(c) City or town Old Philadelphia Road. (If outside city or town limits, write RURAL, and give town) Fullerton, Md.
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma E. House

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Wm. E. House.
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) March 15, 1886

8. AGE: Years	Months	Days	If less than one day
58	11	17	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Timor Jones
13. Birthplace Maryland.

MOTHER
14. Maiden Name Margaret Wilson.
15. Birthplace Maryland.

16 (a) Informant Wm. E. House
(b) Address Old Philadelphia Rd. Fullerton Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5/45 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Thenowerth & Donovan
(b) Address 3615-17 Christopher Ave.

19 (a) MAR 7 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2 1945, at 6 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14 1945 to 3/2 1945 and that I last saw h[illegible] alive on 3/2 1945.

Immediate cause of death	Duration
Cardiac Failure	
Due to Hypertensive Cardio Vascular Disease	
Due to	
Other Conditions Acute Cholecystitis	

(Include pregnancy within 3 months of death)
Date of operation 2/21/45
Major findings of operation: Cholecystitis Cholelithiasis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Melvin J. Jenovese M.D.
Address St. Joseph's Hospt. Date signed 3/3/45

VS 180

66510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1864a

Registered No. 66510

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert and 33rd Sts.

(c) Hospital or institution: The Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days

(e) Length of stay in Baltimore (yrs., mos., or days) 83yrs 5days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Cecil Apts 1123 N. Eutaw Place (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Susan Turnbull Murdoch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 27, 1862

8. AGE: Years 83 | Months 0 | Days 5 7 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Alexander F. Murdoch

13. Birthplace Md

MOTHER

14. Maiden Name Florence Davies

15. Birthplace Md

16 (a) Informant Hosp Record

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 6 45 (month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Balto Md

18 (a) Funeral director Henry McLaughlin & Sons Co

(b) Address McCulloh & Oakland

19 (a) MAR 5 - 1945 (Date received by registrar) (b) Hunting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4, 1945 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from February 24 1945 to March 4, 1945, and that I last saw her alive on March 4, 1945

Immediate cause of death: Cardio-respiratory Failure — Duration

Due to: Arteriosclerotic Cardiovascular Disease

Due to:

Other Conditions: Hypertension; Intertrochanteric Fracture of right hip.

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: N/A

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence February 27 1945 A. M.

(c) Where did injury occur? Baltimore, Md. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? At home While at work? No (Specify type of place)

(e) Means of injury Fell to floor

23. Signature J. Frank Supplee, III

Address Union Memorial Hospital Date signed 3/4/45 M. D.

VS 150

& John R. Davis, Howard L. Mengert, M.D.

G26511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No. G26511

Every item of information should be carefully supplied. The write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. o. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Welcome Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur S. White

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1924

8. AGE: Years 21 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Live Oak Florida (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William White
13. Birthplace Florida

MOTHER
14. Maiden Name Hester Cross
15. Birthplace Florida

16 (a) Informant Mary Headspeth
(b) Address 507 Welcome Alley

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co Md

18 (a) Funeral director Daniel L Brown Son
(b) Address 108 W Montgomery St

19 (a) Authority by [illegible] (b) [illegible] Registrar

MAR 5 1945
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1945, at 7 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/28/45 at 10 P. M.
(b) Where did injury occur? Hamburg & Sharp Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Stabbed during altercation

23. Signature Paul Lee Gratton M.D. Medical Examiner.
Date signed March 1 1945.

626512

JO #92217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 626512

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

MARG RESERVED FOR READING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 939 Linden Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Frazier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Divorced

6 (b) Name of husband or wife Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1894

8. AGE: Years	Months	Days	If less than one day
50	6	16	hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Unable to obtain information

11. Industry or business " " " "

FATHER
12. Name Unable to obtain information.
13. Birthplace " " " "

MOTHER
14. Maiden Name Rhiner
15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Avenue

MAR 5 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1945, at 3:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20, 1945, to March 1, 1945, and that I last saw him alive on Feb. 28, 1945.

Immediate cause of death Uremia — Duration 10 days

Due to Cardiac decompensation — Duration ?

Due to Chronic Nephritis — Duration ?

Due to Hypertension — Duration ?

Other Conditions Labor pneumonia — Duration ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hosp. Date signed 3-3-45

VS 150

1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 626513

626513

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 445 Oxford Ct.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 445 Oxford Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Bishop

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August, 1880

8. AGE: Years 64 | Months 6 | Days | If less than one day — hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name ?
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Nannie Bishop
(b) Address 445 Oxford Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) MAR 5 - 1945 (Date rec'd by registrar) (b) Huntingtor Williams, M.D. (Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-31-44 19 , to 2-27-45 , and that I last saw h alive on 19 .

Immediate cause of death Gastric Carcinoma — Duration 2 mos.

Due to

Due to

Other Conditions Chronic Cardiac disease — 6 mos.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. N. Cardozo M. D.
Address 1524 Druid Hill Ave. Date signed 2-28-45

X

626514
JL - 88954

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

30D

626514
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - 28
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 Ashland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Millard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife John (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15 ?1886

8. AGE: Years 58 ? 59 ? | Months 7? | Days 13 ? | If less than one day ..... hr. ..... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Nancy Robinson
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Ai Ae Ex Md

18 (a) Funeral director Belson Mamie Ka Hough
(b) Address 721 Allequippa St Balto 2-Md

19 (a) 3-5-1945 (Delivered by registrar) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28, 1945, at 9.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 30 1944, to Feb. 28 1945, and that I last saw her alive on Feb. 28, 1945

Immediate cause of death: Cardiac insufficiency — Duration: 7
Due to: Syphilitic heart disease
Due to:
Other Conditions: Syphilitic aortitis Lobar pneumonia — Duration: 7
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Sasue

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
Signature E Woodward M. D.
Address Baltimore City Hospitals Date signed 2-3-46

626515 D.C. # 20851 626515

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1610

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3022 Windsor Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Ruckle

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 3, 1945

8. AGE: Years	Months	Days	If less than one day
			6 hr. 31 min.

9. Birthplace Balto; Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name F. Edgar Ruckle
13. Birthplace Balto; Md

MOTHER
14. Maiden Name Catherine Apern
15. Birthplace Balto; Md

16 (a) Informant Mrs. Cath. Ruckle
(b) Address 3022 Windsor Ave

17 (a) Burial (b) Date thereof 3/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md

18 (a) Funeral director H. A. W. Mears and Son
(b) Address 505 W. Calvert St.

19 (a) MAR 5 - 1945 (Registrar's signature) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 3, 1945, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 3, 1945 to Mar 3, 1945, and that I last saw him alive on Mar 3, 1945.

Immediate cause of death	Duration
C-R Failure	
Due to Erythroblastosis Fetalis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert B. Tunney M. D.
Address Mercy Hosp Date signed 3/3/45

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1940 626516 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 636 Perkins ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 636 Perkins ave (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Josiah Walker.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	married

6 (b) Name of husband or wife Jane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 — 25 — 1870

8. AGE: Years	Months	Days	If less than one day
74	3	17	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name ? Walker

13. Birthplace Va

MOTHER 14. Maiden Name Dunnaway

15. Birthplace Va

16 (a) Informant Jane B Walker.

(b) Address 636 Perkins Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location Baltimore Md

18 (a) Funeral director Mrs. Urania A. Hunley

(b) Address 578 W. Biddle St.

19 (a) 3/5/45 (Date rec'd by registrar) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1945, at 8 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1945, to Mar 2 1945; and that I last saw h/m alive on Mar 1 1945.

Immediate cause of death	Duration
Coronary Occlusion	2 days
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas Sheppard M. D.

Address 1631 N Franklin Date signed 3-3-45

X

626517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

178a

Registered No. 626517

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days) 3 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2129 St Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew M. Edwards

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ or wife Doris Edwards
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22-190[illegible]

8. AGE: Years	Months	Days	If less than one day
38	10	10	hr. min.

9. Birthplace Franklin Co. N.C.
(Town, county, and state)
10. Usual Occupation Electric Welder
11. Industry or business

FATHER
12. Name S E Edwards
13. Birthplace Nash Co N.C.

MOTHER
14. Maiden Name Georgie Eva Gardner
15. Birthplace Nash Co N.C.

16 (a) Informant Mrs Doris Edwards
(b) Address Rocky Mount N.C.

17 (a) Removal (b) Date thereof (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory ?
Location Rocky mount N.C.

18 (a) Funeral director A Reiley Slade
(b) Address 407 Myrtle Road

19 MAR 5 - 1945 Hunter Jos Williams Jr. M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2- 1945, at 4 15 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Accumulation Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-2-45 at 128 P. M.
(b) Where did injury occur? 101 S. 27th St.
(c) Did injury occur at home, on farm, industrial place, in public place? House While at work? No
(d) Means of injury Unlit gas stove jets.

23. Signature Howard J. Mulder M.D.
Medical Examiner.
Date signed 3-3-45

66518

BALTIMORE CITY HEALTH DEPARTMENT X 457

CERTIFICATE OF DEATH

Registered No. 66518

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 12/7/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 12/7/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Somerset
(c) City or town Crisfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. - (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SOMERS, Mary Annie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Married

6 (b) Name of husband or wife James T. Somers
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) June 9, ~~1895~~ 1896

8. AGE: Years	Months	Days	If less than one day
~~48~~ 48	8 7	17	hr. min.

9. Birthplace Accomac Co., Va. (Town, county, and state)
10. Usual Occupation Cook - Merchant Marine
11. Industry or business

FATHER
12. Name Alexander W. Marshall
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Anna Ayres
15. Birthplace Va.

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/45 (month) (day) (year)
(c) Cemetery or crematory Asbury
Location Lanfield Md

18 (a) Funeral director Howard H Hubbard
(b) Address 36 Main St. Lanfield Md

19 (a) 2/28/45 (Date rec'd by registrar) (b) C. E. Collins, M.D. Registrar
Huntington Williams, M.D.

MAR 5 - 1945

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Feb. 26, 1945, at 5:17 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7, 1944, to Feb. 26, 1945, and that I last saw him alive on Feb. 26, 1945.

Immediate cause of death Carcinoma right side of mouth with extension into right mandible and neck ~~xxx~~ with massive ulceration. — Duration 1 yr. approx.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Benjamin F. Jones M. D.
Address Baltimore, Md. Date signed 2/27/45

(Over) MS-57380

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

626519

Registered No. 124B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: Univ Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dor
(c) City or town Fishing Creek
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Hoffman

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Minnie Hudson
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/29/1880

8. AGE: Years 64 | Months 10 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Retired Waterman

11. Industry or business

FATHER
12. Name James W. Hoffman
13. Birthplace

MOTHER
14. Maiden Name Emma? Scott
15. Birthplace Va.

16 (a) Informant Mrs Minnie Nelson
(b) Address 2405 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/45 (month) (day) (year)
(c) Cemetery or crematory Lensfield
Location Lensfield Md

18 (a) Funeral director Edward H. Hubbard
(b) Address 306 Main St. Lensfield Md

19 (a) 2/21/45 (Date rec'd by registrar) (b) C. E. Collins, M.D. Registrar

VS MAR 5 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/20 1945 at 2 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15 1945 to 2-20 1945 and that I last saw h alive on 2-20 1945

Immediate cause of death Cirrhosis of Liver
Due to Abd Ascites
Due to Pulmonary Edema
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Ray Jay Thompson M. D.
Address Redwood & Green Date signed 2/20/45

626520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. 626520

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gallaway & Fayette Sts
(c) Hospital or institution Hampton Square 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3046 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Rowland

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 60? | Months 7 | Days - | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name John Humphreys
13. Birthplace Va

MOTHER 14. Maiden Name Mary Baker
15. Birthplace Va

16 (a) Informant Mrs Katherine Humphreys
(b) Address 51 S. Fulton Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/5/45 (month) (day) (year)
(c) Cemetery or crematory Redemption
Location

18 (a) Funeral director F. B. Kirkland Inc
(b) Address 310 Eutaw St

19 (a) MAR 5 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4th 1945, at 6 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5, 1945, to Feb. 27, 1945, and that I last saw her alive on Feb. 27, 1945.

Immediate cause of death	Duration
Coronary Thrombosis	10 min.
Due to Myocarditis & Heart Block	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gerard A Kemp M.D.
Address 3030 Edgondson Ave. Date signed 3/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

X

G26521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G26521

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1215 North Bond
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 North Bond (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Faulcon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Sadie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace N. Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Co

FATHER
12. Name Melvin Faulcon
13. Birthplace N. C.

MOTHER
14. Maiden Name Matilda Lee
15. Birthplace N. C.

16 (a) Informant Sadie Faulcon
(b) Address 1215 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 8-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robert A. Elliott
(b) Address

19 MAR 5 - 1945 (b) Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4, 1945, at 1:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 3/4/45

G66522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G66522

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1709 Baker St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Baker St
(If rural give location)
(e) Citizen of foreign country? (Yes / No)
If yes, name country

3 (a) FULL NAME Alestus Armister Rusk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1877

8. AGE: Years	Months	Days	If less than one day
77	10	25	hr. 18 67 min.

9. Birthplace Eastern Shore Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Abram Chase
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Candes
15. Birthplace Md.

16 (a) Informant Samuel Rusk
(b) Address 1709 Baker St

17 (a) Burial (b) Date thereof March 7 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Baltimore County Md.

18 (a) Funeral director Mrs. Robert A. Ellis & Dpt
(b) Address 1299 N. Caroline St.

19 MAR 5 - 1945 Huntington Willis Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 19 45, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to March 1 19 45, and that I last saw h alive February 28 19 45.

Immediate cause of death Bronchopneumonia — Duration 1 wk

Due to Arteriosclerosis — 6 yrs.

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Hadnow Higgins M. D.
Address 243 Madison Ave Date signed 3/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-150

G266523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G266523

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3409 Brentwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 Brentwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henrietta Jefferson
3 (b) If veteran, name war
3 (c) Social Security Account No. —
4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Rufus
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 13, 1871
8. AGE: Years 73 | Months 5 | Days 20 | If less than one day hr. min.
9. Birthplace Va. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Cyrus Rodgers
13. Birthplace Va

MOTHER
14. Maiden Name Carolina ?
15. Birthplace Va.

16 (a) Informant Florence Jefferson
(b) Address 3409 Brentwood Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location A A County Md.
18 (a) Funeral director Mrs. Robert A. Ellis
(b) Address 629 N. Gardner St.
MAR 5 - 1945 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch 3, 1945 at 7.9 M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27, 1945 to Mch 3, 1945 and that I last saw her alive on Mch 3, 1945

Immediate cause of death	Duration
Chronic Nephritis	5 yrs.
Cardiac Decompensation	Febrs.
Due to General Arteriosclerosis	yrs.
Due to —	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —
23. Signature Wm. M. Pannebaker M. D.
Address 2740 St. Paul St. Date signed Mch. 5, 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS 150

G265524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. G265524

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 6 14
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs 8 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 11 (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Elizabeth A. Meads or Meade

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Milton T. Meads
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1866

8. AGE: Years 78 | Months 4 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Harford County, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Nathaniel Heaps
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Rebecca Strawbridge
15. Birthplace Harford Co., Md.

16 (a) Informant Home for Incurable Records
(b) Address 700 W. 40th St - M. F. H.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/45 (month) (day) (year)
(c) Cemetery or crematory McKendree Cem.
Location Harford Co., Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) MAR 5 - 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 3, 1945, at 1:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....; and that I last saw h..... alive on ..... 19.....

Immediate cause of death	Duration
Congestive Heart Failure	8 weeks
Due to Hypertensive Cardio Vascular Disease	10 years
Due to	
Other Conditions Arteriosclerosis Multiple Joints (Include pregnancy within 3 months of death)	32 years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thomas Conrad Wolff M.D.
Address 11 E. Chase St. Date signed 3/3/45

G66525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59B

Registered No. G66525

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1206 Cleveland Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Cleveland Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE B. SCHNECK

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Irene J. Schneck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1891

8. AGE: Years	Months	Days	If less than one day
53	10	14	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Gasoline Operator
11. Industry or business

FATHER
12. Name Charles Schneck
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Leutner
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Louise Reier
(b) Address 722 Braeside Road

17 (a) Burial (b) Date thereof 3/6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Maryland
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Maryland
19 (a) MAR 5 - 1945 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 6, 1936 to March 3, 1945, and that I last saw him alive on March 3, 1945.

Immediate cause of death	Duration
Chronic Multiple Arthritis	8 yrs.
Due to Myocardial Insufficiency	2 wks.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A. Kupp, M.D.
Address 3030 Edmondson Ave. Date signed 3/5/45

VS 150

626526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1440

626526 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day, 9 hours
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Rejester Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] Boyce (Lena B.)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mr Clarence B. Boyce

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 24, 1915

8. AGE: Years 29 | Months 7 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Harmon N.Y. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Harry Beatty

13. Birthplace Harriman, N.Y.

MOTHER 14. Maiden Name Ethel Beatty

15. Birthplace Harriman N. Y.

16 (a) Informant Husband

(b) Address 701 Rejester ave., Balto, Md. +12

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/6/45 (month) (day) (year)

(c) Cemetery or crematory Hamptonburgh Cem.

Location Campbell Hall, N. Y.

18 (a) Funeral director Wm. J. Tyrone & Sons

(b) Address Balto, Md. Williamsport, Md.

19 MAR 5 - 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1944 to March 4 1945, and that I last saw her alive on March 4 1945.

Immediate cause of death: Eclampsia with Convulsions. — Duration 1 week

Due to —

Due to —

Other Conditions Pregnancy 25 Weeks - undelivered
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury

23. Signature John G. Murray Jr. M.D.

Address 9 Fortchase Rd. Date signed March 4-45

VS 150

G26527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G26527

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address the 33rd & Calvert Sts
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3331 Mondawmin ave
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Harriet Rebecca FORREST

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widow.

6 (b) Name of husband or wife Capt. Charles M. Forrest.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/16/1860

8. AGE: Years 84. Months 4 Days 17 If less than one day hr. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

MOTHER / FATHER

12. Name George M. Hay
13. Birthplace Md.
14. Maiden Name Sabina R. Lewis
15. Birthplace Va

16 (a) Informant Mr. W. Russell Myles
(b) Address 713 Wyndon Ave

17 (a) Burial (b) Date thereof 3/6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or Crematory Arlington Natl. Cem.
Location Arlington Va.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) [illegible] 1945 (b) [illegible] Washington Williams
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3/45 19 at 12:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/2 1945 to 3/3 1945 and that I last saw he alive on 3/3 1945.

Immediate cause of death Cardiorespiratory failure.

Due to Chronic Heart Failure

Due to Hypertensive Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred Hawkins Jr MD

Address Union Memorial Hosp. Date signed M. 3 D. 3/45

VS 150

626528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

626528 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4000 Norfolk Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Kornblatt

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 50 | Months | Days | If less than one day: hr. min.

9. Birthplace Rumpy
(Town, county, and state)

10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Isachar Pomeranty
13. Birthplace R.
14. Maiden Name Esther
15. Birthplace Rumni

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnel St

18 (a) Funeral director Jack Levinson
(b) Address 1439 E. Balto St

19 MAR 5 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 4 1945, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945 to Mar 4 1945; and that I last saw h[illegible] alive on Mar 4 1945.

Immediate cause of death: Cardio Respiratory Failure — Duration
Due to Carcinomatosis
Due to Carcinoma of Breast
Other Conditions Chronic Ulcerative Colitis -
(Include pregnancy within 3 months of death)
Date of operation 10/15/42
Major findings of operation: Scirrhus Carcinoma of Breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Brown, M. D.
Address Sinai Hospital Date signed 3/4/45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 266529

266529

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3207 Baker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar C. Hearn

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Hester R
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1869

8. AGE: Years	Months	Days	If less than one day
76	-	-	hr. min.

9. Birthplace Delmont Delaware
(Town, county, and state)
10. Usual Occupation Supervisor
11. Industry or business Balto. Transit Co.

FATHER
12. Name — Hearn
13. Birthplace Delaware

MOTHER
14. Maiden Name —
15. Birthplace Delaware

16 (a) Informant Mrs Hester Hearn
(b) Address 3207 Baker St

17 (a) Burial (b) Date thereof 3/6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loraine
Location Woodlawn Md

18 (a) Funeral director Harry A Witzke
(b) Address 4101 Edmondson Ave

19 MAR 5 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by local Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1945; at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23 1945, to Mar. 3 1945, and that I last saw him alive on Mar. 3 1945.

Immediate cause of death	Duration
Arteriosclerotic cardio vasc. disease	
Due to	
Due to	
Other Conditions Fractured right femur (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 16/7
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Jan. 23 at M
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public place (Specify type of place) While at work? No
(e) Means of injury Fell on sidewalk

23. Signature Frank G. Lukato M.D.
Address 1213 Light St. Date signed 3/3/45

For P. C. J. Lubinski, by Howard J. Mueller, M.D.

626530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 626530

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. RFD #9 Box 547
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES ~~ROBERSON~~ ROBINSON

3 (b) If veteran, name war ?

3 (c) Social Security Account No. 219-01-9237

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife SADIE ROBINSON
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) MARCH 7 1878

8. AGE: Years	Months	Days	If less than one day
66	10	24	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation LABORER
11. Industry or business ?

FATHER	12. Name	NOT KNOWN
	13. Birthplace	"
MOTHER	14. Maiden Name	"
	15. Birthplace	"

16 (a) Informant SADIE ROBINSON
(b) Address BELL GROVE Rd. BROOKLYN-25

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A.A. Co.

18 (a) Funeral director Bernard C Hartle
(b) Address 121 E West St

19 MAR 5 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1945, at M

21. I certify that I took charge of the remains described above, held an Inspection and Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Dec's death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 3/8/45

VS 151

626531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 626531 1314

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3425 Paton ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 3425 Paton ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geneva Beckett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-2-1899

8. AGE: Years 45 | Months 8 | Days 2 | If less than one day hr. min.

9. Birthplace Eastern Shore, Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Wm. Simpkins
13. Birthplace Va.

MOTHER
14. Maiden Name Rebecca ?
15. Birthplace Va.

16 (a) Informant Elizabeth Staley
(b) Address 3426 Paton ave

17 (a) Burial (b) Date thereof 3 7 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A.A. County Md

18 (a) Funeral director William L. Jackson
(b) Address 916 Pennsylvania ave

19 (a) MAR 5 - 1945 (b) Huntingtown Calvert Co Md
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1945, at 7:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary - Thrombosis Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Woodin M.D.
Medical Examiner.
Date signed 3-5-45

G26532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

96

G26532 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 657 W. Lee ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruth Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation maid

11. Industry or business

FATHER
12. Name Levin Macer
13. Birthplace md

MOTHER
14. Maiden Name Salena Lee
15. Birthplace md

16 (a) Informant Salena Macer
(b) Address 651 W. Lee St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Taylor
(b) Address 142 W. Hiel St

19 (a) MAR 5 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1945, at 1 15 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Lee death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid hemorrhage, spontaneous

Due to Ruptured aneurysm of anterior Cerebral Artery

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Grafton M.D. Medical Examiner.
Date signed March 5 1945

G26533 BALTIMORE CITY HEALTH DEPARTMENT G26533
CERTIFICATE OF DEATH 1310 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1903 N. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 N. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carolyn Sauers
3 (b) If veteran, name war
3 (c) Social Security Account No. —
4. Sex F
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 17, 1886
8. AGE: Years 58 Months 10 Days 15 If less than one day hr. min.
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name Frederick Wolfe
13. Birthplace Balto. Md
MOTHER 14. Maiden Name Anna —
15. Birthplace Balto. Md
16 (a) Informant Jane L. Glaenzer
(b) Address 1927 N. Lombard St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/45 (month) (day) (year)
(c) Cemetery or crematory Res. Cathedral
Location Edmondson ave
18 (a) Funeral director Howard N. Bligh Jr
(b) Address 4914 Belair Road
19 (a) (b) (Date rec'd by registrar)

MAR 5 1945 Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1945, at 5:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3 1945 to 3/5 1945 and that I last saw h[illegible]ive on 3/4 1945.

Immediate cause of death: cardiac failure — Duration
Due to Hemiplegia - right
Due to Hypertensive cardiovascular renal disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Shorb Glaenzer
Address 6018 N. Monroe St Date signed 3/5/45

G26534 ✓ G26534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

CWK 78501

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2 24
(e) Length of stay in Baltimore (yrs., mos., or days) 75 10 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice E. Kelty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charlie Kelty (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17-1869

8. AGE: Years 75 | Months 10 | Days 16 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore-Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Pierpont
13. Birthplace Md.

MOTHER
14. Maiden Name Jane Wright
15. Birthplace Md.

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto.

18 (a) Funeral director Geo. A. Huntzinger
(b) Address 4020 Old York Rd.

19 (a) Huntingtown, Williams, M.D. (Filled in by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3- 1945 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1942, to 3-3- 1945, and that I last saw her alive on 3-3- 1945.

Immediate cause of death: Bronchopneumonia — Duration: ?

Due to

Due to

Other Conditions: Arteriosclerotic heart disease — Duration: ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H. M. Phillips M. D.

Address Balt City Hosp Date signed 3-6-45

5-1945

107

G26535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G26535 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1149 Whatcoat St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balti more
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1149 Whatcoat St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sam H. ~~Erkauls~~ ERKAUMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 44 OR Months mos. Days If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation State Treasure

11. Industry or business Department - Solons.

FATHER
12. Name Wm. H. Erkaums
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Mary Holly
15. Birthplace Richmond, Va.

16 (a) Informant Miss Grace Erkaums
(b) Address 1149 Whatcoat St.

17 (a) Burial (b) Date thereof Mar. 5, '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. Katie R. Willigan
(b) Address 322 N. Schroeder St.

19 (a) MAR 5 1945 (b) For Williams M.D. Registrar
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1 1945, at 12.01 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rheumatic Cardio-vascular disease

Due to

Other Conditions Pulmonary Tuberculosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dwight B. McNulty M.D.
Medical Examiner.
Date signed 3/2/45

93C

626536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12 4B

626536 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 530 E. Fort Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. Md. (If outside city or town limits, write RURAL and give town)

(d) Street No. 530 E. Fort Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Earl W. Knight.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	M.

6 (b) Name of husband or wife Mildred D. Knight

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1899

8. AGE: Years	Months	Days	If less than one day
45	5	23	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Steel Worker

11. Industry or business

FATHER 12. Name John P.

13. Birthplace Md.

MOTHER 14. Maiden Name Sarah S. Hoffman

15. Birthplace Md.

16 (a) Informant Family

(b) Address 530 E. Fort Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3-7-45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto. Md.

18 (a) Funeral director H. H. Lambert

(b) Address 32 E. Fort Ave.

19 (a) (Date rec'd by registrar) (b) MAR 5 - 1945 Registrar

Huntington Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1945, at 12 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1945 to March 4 1945, and that I last saw h. alive on March 3 1945.

Immediate cause of death Cirrhosis of the Liver

Due to

Due to

Other Conditions Pulmonary Edema - Myocarditis

(include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN. Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)

(e) Means of injury —

23. Signature John A. Schenuit M.D.

Address 1337 S Charles St Date signed 3/5/45

X

G26537

BALTIMORE CITY HEALTH DEPARTMENT ✓ G26537

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3202 Fernhill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3202 Fernhill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anne Murray

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 877

8. AGE: Years	Months	Days	If less than one day
67	8	13	hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Groth
15. Birthplace Md.

16 (a) Informant Family
(b) Address 3202 Fernhill Ave

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3-6-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director J. L. McCauley
(b) Address 3[illegible] Eas[illegible]

MAR 5 1945

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1945, at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1945, to March 3 1945, and that I last saw her alive on March 3 1945.

Immediate cause of death	Duration
1) - Cerebral Hemorrhage	- 3 days.
Due to Cerebral Hemorrhage also	15 yrs
Due to	
Other Conditions - Epilepsy	54 yrs?

(Include pregnancy within 3 months of death)

Date of operation - None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Earl L. Chambers M. D.
Address 4108 Liberty Hts. Date signed 3/5/45

VS 150

X

626538 ✓ 626538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

626538 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1026 N. Gay Street (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Elmer H. Ritz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1916

8. AGE: Years 28 | Months 3 | Days 12 | If less than one day .....hr. .....min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Penna R.R.

FATHER
12. Name George Ritz
13. Birthplace Germany

MOTHER
14. Maiden Name Minnie Quantmeyer
15. Birthplace Balto. Md

16 (a) Informant Mrs. Minnie Ritz
(b) Address 1026 N. Gay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore — Location E. North Ave.

18 (a) Funeral director E. Eshleman & Son (Successor to C. Vern Lemmon)
(b) Address 1039 Eastern Ave.

19 (a) 1945 (Date received by registrar) (b) Washington Hill Registrar

MAR 5

OS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1945 at 4 50 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Less death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid hemorrhage traumatic
Contusion of lungs

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 26/4

(a) Date of injury March 4, 1945 4:10 P.M.
(b) Where did injury occur? Orangeville Engine House P.R.R.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury: Struck by mail

23. Signature Robert Lee Graham M.D.
Medical Examiner.

Date signed 3-5-45

LOCAL

626539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

626539 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 299 Herring Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 299 Herring Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Kiddy

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 264-05-1159

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Carrie Kiddy

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1901

8. AGE: Years 43 | Months 5 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Elkins West Virginia (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Bethlehem Shipyard

FATHER 12. Name Robt. Kiddy

FATHER 13. Birthplace West Virginia

MOTHER 14. Maiden Name unknown

MOTHER 15. Birthplace

16 (a) Informant Mrs. C. Kibley KIDDY

16 (b) Address 299 Herring Court

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Mar. 6/42 (month) (day) (year)

17 (c) Cemetery or crematory .....
Location Savannah Georgia

18 (a) Funeral director Fred A. Hamel & Son

18 (b) Address 1216 N. Charles St.

19 (a) 1945 (Date rec'd by registrar) (b) Registrar Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3rd 1945, at 1:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed March 4 1945

VS 151

X

G26540 BALTIMORE CITY HEALTH DEPARTMENT G26540
CERTIFICATE OF DEATH 931 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32nd & Calvert Sts.
(c) Hospital or institution: Union Memorial.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Oldham St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Greece.

3 (a) FULL NAME Theodore Kontaxes
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept ?, 1899
8. AGE: Years 45 Months 6 Days ? If less than one day hr. min.
9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Steel Worker
11. Industry or business Bethlehem Steel.
FATHER 12. Name Mr Nicholas Kontaxes
FATHER 13. Birthplace Greece
MOTHER 14. Maiden Name Clara ?
MOTHER 15. Birthplace Greece.
16 (a) Informant Hospital Record
16 (b) Address 32 & Calvert St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 8. 1945 (month) (day) (year)
17 (c) Cemetery or crematory Greek Cemetery
Location Wilkens Ave & Monroe St.
18 (a) Funeral director LAMBOS INC.
18 (b) Address 1140 E. North Ave
19 (a) MAR 5 1945 (Date received by registrar) (b) Harrington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4/1945 at 6:45 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 2/27/1945 to 3/4/1945 and that I last saw him alive on 3/4/1945.
Immediate cause of death Cardio-respiratory failure
Due to Uremia
Due to Congenital Polycystic Kidneys
Other Conditions Arteriosclerotic Heart Disease Angina Pectoris.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Fred Hawkins, Jr M.D.
Address Union Memorial Hosp Date signed 3/10/45 M. D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G26541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G26541

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1254 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hilda Larson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-17-95

8. AGE: Years 49 | Months 2 | Days 16 | If less than one day hr. min.

9. Birthplace Wisc. (Town, county, and state)

10. Usual Occupation nurse

11. Industry or business

FATHER
12. Name Ezra Larson
13. Birthplace Norway

MOTHER
14. Maiden Name Alice Higgs
15. Birthplace Norway

16 (a) Informant Records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-45 (month) (day) (year)
(c) Cemetery or crematory Lakewood Cemetery
Location Minneapolis, Minnesota

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

19 MAR 5 - 1945 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-3 1945, at 2 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7 1944 to 3-3 1945, and that I last saw h alive on 3-3 1945

Immediate cause of death	Duration
Carcinomatosis & Cachexia	4 months
Due to Carcinoma of Breast	5 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None this admission

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan C. Woodruff M.D.
Address Johns Hopkins Hospital, Balto. Date signed 3/9/45

G26542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G26542 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 131 N Montgomery
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 131 N Montgomery (If outside city or town limits, write RURAL and give town)
(d) Street No. Balto (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Friederika Stroke

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles Stroke
6 (c) If alive, give age 88 years

7. Birth date of deceased (mo., day, yr.) 2/12/1857

8. AGE: Years 88 | Months - | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business At home

FATHER
12. Name Frederick Palen
13. Birthplace Germany

MOTHER
14. Maiden Name Minnie Ellis
15. Birthplace Germany

16 (a) Informant Augusta Strake
(b) Address 131 N. Montgomery

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto Co Md

18 (a) Funeral director Lehnert Funeral Home
(b) Address 2008 Eldersl
Huntington Williams, M.D. Registrar

19 (a) (Date rec'd by registrar) MAR 5 - 1945

MEDICAL CERTIFICATION

55

20. DATE OF DEATH March 4 19 45, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 19 45, to Mar 4 19 45, and that I last saw h alive on Mar 3 1945.

Immediate cause of death	Duration
Bronchopneumonia	1 week
Due to	
Due to Total Blindness	5 years
Other Conditions Arteriosclerosis Senility (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M. D.
Address 1225 N Arlington St Date signed 3/5/45

X

626543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 626543

AB-72205

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs- 11mos-18days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 S. Fremount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hampton Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Susie (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12- 1880

8. AGE: Years 64 | Months 7 | Days 8 | If less than one day hr. min.

9. Birthplace S.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Williams
13. Birthplace S.C.

MOTHER
14. Maiden Name Kigh ? or Kiah ?
15. Birthplace S.C.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 5 - 1945

18 (a) Funeral director Commissioner of Health

(b) Address

MAR 5 - 1945 (Huntington Williams, M.D.)
(Date received) (Registrar) Registrar

MAR 5 - 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20- 1945, at 8.35AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2- 1942 to 2-20- 1945, and that I last saw him alive on 2-20- 1945.

Immediate cause of death	Duration
uremia	
Due to hypertensive cardiovascular disease	
Due to	
Other Conditions hypertensive cardiovascular disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. A. Perry Jr. M. D.
Address City Hosp. Date signed 2-26-45

2555

X

G26544

BALTIMORE CITY HEALTH DEPARTMENT

AB- 86171

CERTIFICATE OF DEATH 937

Registered No. G26544

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 707 Penna. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14-1882

8. AGE: Years	Months	Days	If less than one day
62	3	11	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Cliv Johnson (D)
13. Birthplace Virginia

MOTHER
14. Maiden Name Cora Andrews (D)
15. Birthplace Virginia

16 (a) Informant Records) Baltimore City Hospitals
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL MAR 5 - 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 5 - 1945 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 250

2554

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25- 1945 at 2.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25- 1944, to 2-25- 1945, and that I last saw him alive on 2-25- 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Cerebral fibrosis & chronic Hypertension & heart disease	7
Due to	
Other Conditions Generalized arteriosclerosis	2

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospital Date signed 3-2-45

X

G26545 ✓ G26545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

Registered No.

G26545

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 215 N. Schroeder St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 N. Schroeder St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard Bates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Ella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Essex Co., Virginia
(Town, county, and state)

10. Usual Occupation Farmer.

11. Industry or business

FATHER
12. Name William Bates.
13. Birthplace Virginia

MOTHER
14. Maiden Name Claria
15. Birthplace Virginia

16 (a) Informant Nancy Bates.
(b) Address 1047 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 5 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAR 5 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1945, at 3 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1945 to Mch 2 1945; and that I last saw h— alive on 3/2 1945.

Immediate cause of death Cardio-Renal — Duration 5 Days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. J. Halaker

Address 1225 Pine St. Date signed 3/5/45

X

G26546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

G26546 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 908 N. Bradford
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 84 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 908 N. Bradford Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John V. Svec

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of ~~husband~~ or wife Marie (nee Klima)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept.22,1860

8. AGE: Years	Months	Days	If less than one day
84 yrs.	5	12	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Joseph Svec
13. Birthplace Czech

MOTHER
14. Maiden Name Unknown
15. Birthplace Czech.

16 (a) Informant Anthony Svec (son)
(b) Address 908 N. Bradford Street

17 (a) Burial (b) Date thereof 3/7/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1945 at 6:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22 1945 to March 4 1945 and that I last saw h~~im~~ alive on March 3 1945

Immediate cause of death Carcinoma of Prostate — Duration

Due to

Due to

Other Conditions Arteriosclerotic Cardio-Vascular Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Simon Krager M. D.
Address 2419 Orleans Date signed 3/4/45

626547 HEALTH DEPARTMENT—CITY OF BALTIMORE 626547

CERTIFICATE OF DEATH

159

1. PLACE OF DEATH

Registered No. A

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 746 W. Baltimore St. Ward)

Length of residence in city or town where death occurred ..yrs. ..mos. 4 How long in U. S. If of foreign birth? ..yrs. ..mos. ..ds.

2. FULL NAME Theresa Burke

If U. S. Veteran specify WAR

(a) Residence: No. 746 W. Baltimore St., ..Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Mar 1 24

7. AGE Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore
(State or country)

FATHER

13. NAME Douglas Flint

14. BIRTHPLACE (city or town) Virginia Western
(State or country) Va

MOTHER

15. MAIDEN NAME Florence Chisholm

16. BIRTHPLACE (city or town) Barren Fosters
(State or country) Va

17. INFORMANT Douglas Flint
(Address) 746 W. Baltimore

18. BURIAL, CREMATION, OR REMOVAL
Place JOHN HOPKINS MEDICAL SCHOOL Date MAR 5 - 1945 19

19. UNDERTAKER Commissioner of Health
(Address)

20. Filed MAR 5 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Mar 1, 1945

22. I HEREBY CERTIFY, That I attended deceased from Mar 1, 19.., to Mar 1, 1945

I last saw h.. alive on Mar 1, 19.. Death is said to have occurred on the date stated above, at ..m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Pneumonia Bronchial	
6 1/2 months	

Other contributory causes of importance:

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19..

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Henry Klumpp M. D.

(Address) 768 Broadway

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 3

12356 X

G26548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

G26548 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette - John
(c) Hospital or institution: Woman's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 da

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Caroline Road, City
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rone child (Boy) Twin #2

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1945

8. AGE: Years	Months	Days	If less than one day
		2	10 hr. 50 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Dean Milton Rone
13. Birthplace York, Pa.

MOTHER
14. Maiden Name Evelyn Porter
15. Birthplace Baltimore, Md.

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 5 - 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 5 - 1945 (Date rec'd by Registrar) Harriet Taylor Williams M.D. Registrar

VS 150

12557

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2/45 19 , at 2:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27 1945 to Mar 2 1945, and that I last saw him alive on Mar 2 1945.

Immediate cause of death Cardio-respiratory arrest. — Duration

Due to Pneumania — Days

Due to Atelectasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest E. Sanfield M. D.
Address Woman's Hosp. Date signed 3/2/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 6<u>6</u>6549

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 Watson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
46	1		hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 5 - 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 5 - 1945 Washington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20-1945 at 9 20 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Cardiac Failure

Due to

Other Conditions Chronic Nephritis, Emphysema, Arteriosclerosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Welsh M.D.
Medical Examiner.
Date signed 2-21-45

2538

G26550

BALTIMORE CITY HEALTH DEPARTMENT 197765 G26550 Registered No.

CERTIFICATE OF DEATH 161a

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 555 New Pittsburgh Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ralph Turnipseed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-20-45

8. AGE: Years | Months | Days | If less than one day hr. 10 min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Sonie Turnipseed
13. Birthplace South Carolina

MOTHER 14. Maiden Name Roberta Crosby
15. Birthplace South Carolina

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 5 - 1945

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 5 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 1945 at 8:35A

21. I certify that death occurred on the date above stated; that I attended deceased from February 24 1945 to Feb. 24 1945. and that I last saw him alive on Feb. 24 1945.

Immediate cause of death ? Massive Atelectasis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. L. Griffith M. D.
Address Johns Hopkins Hospital Date signed 2-26-45

2359

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-92352 G26551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G26551 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 6yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 Annabell Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John William Quinn

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth Kennedy Quinn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3-1882

8. AGE: Years	Months	Days	If less than one day
63	-	1	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation Cabinet Maker
11. Industry or business Jones woodworker

FATHER
12. Name William Quinn
13. Birthplace N C

MOTHER
14. Maiden Name Lucy Phillips
15. Birthplace N C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/45 (month) (day) (year)
(c) Cemetery or crematory Myrtle Grove
Location Wilmington N.C.

18 (a) Funeral director John F Denny Inc
(b) Address 715 Light St.

19 (a) 1945 (Local File No. by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4- 1945, at 9.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28- 1945, to 3-4- 1945, and that I last saw him alive on 3-4- 1945

Immediate cause of death	Duration
Cardiac failure	3 days
Due to Acute endocarditis	
Due to	
Other Conditions Brain abscess Pneumococcic meningitis Lobar pneumonia (Include pregnancy within 3 months of death)	3 days?

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Woodward M. D.
Address Baltimore City Hospitals Date signed 3-4-45

912

G26552 ✓ G26552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Registered No. <

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 821 S. Charles St.
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME JONN KOLESKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Emma Koleski (Schultz)

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 4/15/882

8. AGE: Years 63 | Months — | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Carman

11. Industry or business Western Md. R.R. Co.

FATHER
12. Name Paul Koleski
13. Birthplace Russia

MOTHER
14. Maiden Name Maria Buliski
15. Birthplace Russia

16 (a) Informant Mrs. Emma Koleski
(b) Address 821 S. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director John F. Kenney Inc.
(b) Address 715 Light St.

19 (a) ____ (b) ____
(Date filed by registrar) Registrar

MAR 5 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-1-1945, at 6⁰⁰ ? M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-23 1945, to 3-1-1945 and that I last saw h im alive on 3-1-1945.

Immediate cause of death	Duration
Atelectasis ?	8-11 days
Due to Early Diffuse Peritonitis	
Due to Perforated Gastric Ulcer	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation 2-24-45

Major findings of operation: Perforated Gastric Ulcer; Peritonitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. C. Eberly III M. D.

Address University Hosp. Date signed 3-2-45

Huntington Williams, M.D.

X

[redacted] 626553 BALTIMORE CITY HEALTH DEPARTMENT X626553 Registered No. [redacted]

CERTIFICATE OF DEATH 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Oak Hill (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 715 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katie Burton
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race Black
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Hobart Burton
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10-2-94
8. AGE: Years 50 Months 5 Days 2 If less than one day hr. min.
9. Birthplace West Virginia (Town, county and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Anderson Medley
13. Birthplace West Virginia

MOTHER
14. Maiden Name Fannie Priscs
15. Birthplace West Virginia

16 (a) Informant Records
(b) Address

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 3 5 45 (month) (day) (year)
(c) Cemetery or crematory Montgomery
Location West Virginia
18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St
19 (a) MAR 10 1945 Huntington, W. Va. (Registrar) Huntington, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1945, at 9:40 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1945 to March 4 1945, and that I last saw her alive on March 4 1945.

Immediate cause of death Cirrhosis of the liver — post operative.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation 3/3/45
Major findings of operation: Cirrhosis of liver
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lew Chambers
Address Johns Hopkins Hospital Date signed 3/4/45

VS. 150

Please stop at office 626554 undertaker

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 626554

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 329 Dunbrik Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Walden

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 81 | Months 80 | Days | If less than one day hr. min.

9. Birthplace Bells Md (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER 12. Name James Trimble

13. Birthplace Bells Md

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Mrs Grace [illegible]

(b) Address 2214 South Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7 1945 (month) (day) (year)

(c) Cemetery or crematory Bethel Cem.

Location Valley Rd Md

18 (a) Funeral director Williams & Tuckey & Son

(b) Address North & Pennsylvania Aves

19 (a) MAR 6 1945 (Date received by Registrar) (b) Hunting Ton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5 1945, at 1150 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 1945, to 3/5 1945, and that I last saw her alive on 3/5 1945

Immediate cause of death Terminal Pneumonia

Due to

Due to

Other Conditions Chronic myocardial degeneration.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

23. Signature Thos E. Carr Jr

Address St. Agnes Hosp. Date signed 3/5/45

X

626555 Perez V 626555

BALTIMORE CITY HEALTH DEPARTMENT 577 Registered No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Venezuela (b) County
(c) City or town Caracas
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Venezuela S. A.

3 (a) FULL NAME Maria Perez.

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Juan Perez.
6 (c) If alive, give age 8 years

7. Birth date of deceased (mo., day, yr.) 1-29-89

8. AGE: Years 56 | Months - | Days 26 | If less than one day ... hr. ... min.

9. Birthplace S. A.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Gregorio Gonzalez
13. Birthplace S. A.

MOTHER
14. Maiden Name Maria Gonzalez
15. Birthplace S. A.

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/45 (month) (day) (year)
(c) Cemetery or crematory Caracas
Location Caracas Venezuela

18 (a) Funeral director Wilson Cook Co.
(b) Address 1210 Cont St

MAR 6 - 1945 (Date rec'd by registrar) Eugene Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2.25 1945, at 5.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-19-1945 to 2-25 1945.
and that I last saw h[illegible] alive on 2-25 1945.

Immediate cause of death Brain tumor — post operative.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 2/23/45

Major findings of operation: Brain tumor — right temporal lobe.

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rue W. Saunders M.D.
Address Johns Hopkins Hospital Date signed 3/26/45

266556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 266556

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 Park Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Mary R. Manning

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 30th 1874

8. AGE:	Years	Months	Days	If less than one day
	71	1	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Home Dressmaker
11. Industry or business Retired

FATHER
12. Name Mr. Bartholomew Manning
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Ann Smith
15. Birthplace Ireland

16 (a) Informant Annie E. Manning
(b) Address Jenkins Memorial Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 MAR 6 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5/45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1945 to March 5 1945, and that I last saw her alive on March 5 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Cerebral hemorrhage	20 days
Due to Hypertensive C.V.D	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roy Byron Turner, Jr. M. D.
Address Mercy Hospital Date signed 3/5/45

X

66557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 66557

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1144 Montpelier St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1144 Montpelier St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie M. Pryor

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed
6 (b) Name of husband ~~or wife~~: James G. Pryor
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Nov 20th 1881
8. AGE: Years 63 | Months 3 | Days 14 | If less than one day hr. min.
9. Birthplace: Phila Pa (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Joseph C. Houck
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Mary A. Knight
15. Birthplace: N.J.

16 (a) Informant: Harold Pryor
(b) Address: 1144 Montpelier St

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 3/7/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Woodlawn
Location: " Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St

19 (a) Filed MAR 6 1945 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 4th 1945, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1937, to Mar. 4 1945, and that I last saw h-m alive on Mar. 4 1945

	Duration
Immediate cause of death: Cerebral hemorrhage.	12 hrs.
Due to: Hypertension & Arteriosclerosis.	10 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Robt. B. Wright M. D.
Address: Medical Arts Date signed 3/5/45

X

Rest

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63

Registered No. G26558

G26558

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) ~~Hospital or~~ institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Valley - Eager 45 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alonzo Rest.

3 (b) If veteran, name war — W
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) ~~Single, married~~ widowed, or ~~divorced~~: Widowed
6 (b) Name of ~~husband~~ or wife: Mary E Rest
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13th 1875

8. AGE: Years 69 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace New York City (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Laborer

FATHER
12. Name Henery Reest
13. Birthplace

MOTHER
14. Maiden Name Frances Reest
15. Birthplace U S A

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/7/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) MAR 6 - 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch 4 1945 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 - 1945 to Mch 4 - 1945, and that I last saw h~~im~~ alive on Mch 3 - 1945

	Duration
Immediate cause of death: Hemorhage of Lungs	1 day
Due to: Carcinoma Face -	5 months
Due to:	
Other Conditions: Malaria in Lungs	1 month

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed Mch 5-45

X

VS 150

66559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 66559

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 710 W. Fayette st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 W. Fayette st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Newton

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife Gertrude E. Newton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 31st 1870

8. AGE: Years 74 | Months 11 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Howard Co. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name George Newton
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth J. Gaither
15. Birthplace Md.

16 (a) Informant Gertrude E. Newton
(b) Address 710 W. Fayette St.

17 (a) Burial (b) Date thereof 3/8/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Meadow Ridge
Location Dorsey Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 MAR 6 - 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 5th 1945, at 9:30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1945 to Mar 4th 1945
and that I last saw h[im] alive on Mar 4 1945

	Duration
Immediate cause of death: Cerebral Embolism	4 days
Due to: Cardio - Vascular-Renal	5 Years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Hansman M. D.
Address 753 W Fayette st Date signed Mar 5 45

X

G26560 ✓ G26560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 M

Registered No.

Every item of information should be carefully supplied. Please write plainly, with UNFADING INK. Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 Bolton Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Howard Troupe

3 (b) If veteran, name war — NO

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Marie Troupe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11th 1908

8. AGE: Years	Months	Days	If less than one day
37	0	23	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business American Oil Co

FATHER
12. Name Jacob Troupe
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Isabella (Unknown)
15. Birthplace Balto. Md.

16 (a) Informant Marie Veira
(b) Address 2070 Linden Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/7/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

MAR 6 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-4- 1945, at 10.25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Effects exhaust gas
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-4- at P M.
(b) Where did injury occur? American Oil Co - Clarkson & Wells St
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? No
(d) Means of injury: Inhalation Exhaust gas.

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 3-5-45

VS 151

626561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 626561

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 N. Collington ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Andrews

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mary Andrews
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23 1878

8. AGE: Years	Months	Days	If less than one day
66	11	9 11	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Carpenter Contractor

FATHER
12. Name Charles Andrews
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Sarah Bonacraft
15. Birthplace Balto. Md.

16 (a) Informant Mary Andrews
(b) Address 1826 N. Collington Ave

17 (a) Burial (b) Date thereof 3-7-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Ave

18 (a) Funeral director Thos F. Miller Inc
(b) Address 2445 E. Oliver St

MAR 6 - 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1945, at 10 15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary [redacted]

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 5 1945

626562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

626562 ✓

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3739 Elm ave: Rooms
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Charles Allen Thatcher

3 (b) If veteran, name war —

3 (c) Social Security Account No. 268-01-4605

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Mildred Smith Thatcher

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10/19/1900

8. AGE: Years	Months	Days	If less than one day
44	4	15	..... hr. ..... min.

9. Birthplace Ashtabula Ohio
(Town, county, and state)

10. Usual Occupation Dist Eng. Office

11. Industry or business U. S. Army

FATHER
12. Name Charles Augustus Thatcher
13. Birthplace Unknown

MOTHER
14. Maiden Name Ellen Maude —
15. Birthplace Unknown

16 (a) Informant D V Frink
(b) Address Dist Eng. Office U.S. Army Standard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8 1945 (month) (day) (year)
(c) Cemetery or crematory Edgewood Cemetery
Location Ashtabula Ohio

18 (a) Funeral director Harry J. Annacott
(b) Address 4204 Ridgewood Ave

19 (Date received by registrar) MAR 6 - 1945 Huntington Willis Registrar, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-4- 1945; at 1:30 P. M.

21. I certify that I took charge of the remains described above, held an Investigation + Inquest (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating gas -

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, in the following:
(a) Date of injury 3-4-45 at ..... P. M.
(b) Where did injury occur? 3739 Elm ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gas stove - burners unlit.

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 3-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626563 626563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No.

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4222 Sprucewood (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** CHARLES SCHNAUFER

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Clara L Schnaufer

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Sept 20 1878

8. AGE: Years 66 | Months 5 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Balto City Water Dept

11. Industry or business

FATHER 12. Name Don Knox
13. Birthplace Balto

MOTHER 14. Maiden Name Don Knox
15. Birthplace Balto

16 (a) Informant Chas L Schnaufer Sr
(b) Address 4006 Schley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 8 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 208 E Preston St

19 (a) ..... (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar) MAR 6 - 1945
WS 151 0

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4, 1945, at 10:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions Lacerated scalp
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] R Davis M.D.
Medical Examiner.
Date signed 3/5/45

626564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

626564 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 Bruce St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 533 Bruce St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E Reding

3 (b) If veteran, name war

3 (c) Social Security Account No. 2 153 24 8662

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Stella Reding
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Jul 8 1880

8. AGE: Years 64 | Months 7 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER 12. Name Dont Know
13. Birthplace Germany

MOTHER 14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Mrs Stella Reding
(b) Address 533 Bruce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 7th (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Rural

18 (a) Funeral director Wm J Fennell's Sons
(b) Address 2014 E Oliver

19 (a) (Date received by registrar) MAR 6 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4th 1945, at 11.00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1, 1945, to March 4 1945, and that I last saw h[im] alive on March 2 1945.

Immediate cause of death Chronic Myocardial Degeneration — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C L Sabinski, M.D.
Address 5213 Dunmoth Rd Date signed Mar 6 1945

X

626565 BALTIMORE CITY HEALTH DEPARTMENT 108 626565
CERTIFICATE OF DEATH Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 N. Bradford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits write RURAL and give town)
(d) Street No. 112 N. Bradford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry J. Deasel

3 (b) If veteran, name war: World
3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Naomi P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 30-1891

8. AGE: Years 53 | Months 9 | Days 4 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Truck Clerk

11. Industry or business:

FATHER
12. Name: John Deasel
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Mary Wisener
15. Birthplace: Balto. Md.

16 (a) Informant: Naomi P. Deasel
(b) Address: 112 N. Bradford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 8-45 (month) (day) (year)
(c) Cemetery or crematory: Lobyrd
Location: Belair Rd.

18 (a) Funeral director: John A. Mann
(b) Address: 800 E. Balto St

19 (a) MAR 6 - 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1945, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 2 1945, to Mar 4 1945, and that I last saw him alive on Mar 3 1945

Immediate cause of death: (a) Coronary Thrombosis — Duration: 4 days
Due to: (b) Hypertension and Arteriosclerosis — 1 day.
Due to: (c) Acute Pleurisy
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Wm. O. Geyer M.D.
Address 156 N. Melton Ave Date signed 3/5/45

Wm. O. Geyer X

VS 150

G266566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55

G266566
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. This correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 Hillen Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL, and give county)
(d) Street No. 3300 Hillen Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie A. Schroenhals

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed or divorced Married

6 (b) Name of husband or wife Geo. W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21-1880

8. AGE: Years 64 | Months 11 | Days 12 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Lamley
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary A. Bower
15. Birthplace Carroll Co.

16 (a) Informant Geo. W. Schroenhals
(b) Address 3300 Hillen Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director John A. Morgan
(b) Address 420 Greenmount Ave.

19 (a) MAR 6 - 1945 (Date rec'd by registrar) Washington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3- 1945 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 13 1944 to Mch 3 1945 and that I last saw h[illegible] alive on Mch 3 1945

Immediate cause of death	Duration
Carcinoma of Lung & Congestive Lobar Pneumonia	
Due to Carcinoma of breast	one year under 1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

PHYSICIAN

Date of operation Sept 1939. Radical breast
Major findings of operation:
Carcinoma of breast 14 yrs ago.
of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature L. W. Bussey
Address 600 N. Broadway Date signed 3/6/45

VS 180

626567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 626567

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 105 S. Chester. St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md.
(If outside city or town limits write RURAL and give town)
(d) Street No. 105 S. Chester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes J. Bradley.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4 Sex Female

5 Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 26 - 1857

8. AGE: Years 88 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Patrick Bradley
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Mullan
15. Birthplace Ireland

16 (a) Informant Alice B. Bradley
(b) Address 105 S. Chester St.

17 (a) Burial (b) Date thereof March 7-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Cemetery or crematory Most. Cath.
Location Old Frederick Rd.

18 (a) Funeral director John A. Mogan
(b) Address 3020 E. Balto. St.

19 (a) (b)
(Date filed by registrar) Registrar

MAR 6 1945 Registrar for Wills, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1945, at 11 30 AM

21. I certify that death occurred on the date above stated: that I attended deceased from Feby 14 March 1945
and that I last saw h[illegible] alive on March 4 1945.

Immediate cause of death Cerebral Apoplexy — Duration acute

Due to Senile Cerebral Arterio-Sclerosis — Duration ?

Due to Chronic Myocarditis — Duration ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 200 E. Balto St. Date signed 3/6/45

X

VS 150

G66568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1642 Registered No. G66568

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d 0 a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bernard Wiseman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7th 1909

8. AGE: Years 35 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Millbrook W. Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Wiseman
13. Birthplace Millbrook W Va

MOTHER
14. Maiden Name Lenarie Kerrman
15. Birthplace Millbrook W. Va

16 (a) Informant Mrs Daisy Wiseman
(b) Address 3 N Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 6th 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo S. Cook
(b) Address 1701-03 N Patterson Park Ave

19 (a) MAR 6 - 1945 (Date received by local registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25- 1945 at 8:15 P M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Hanging

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-25-45 at 7:45 P. M.
(b) Where did injury occur? Eastern District Police Station
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Hanged self with belt.

23. Signature Howard J. Weldeis M.D. Medical Examiner.
Date signed February 26, 1945

G26569 G26569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2147 Division St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2147 Division St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Nicholson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Col.	Married

6 (b) Name of husband or wife Laurence Nicholson
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Queen Anne County, Md.
(Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Md.

MOTHER
14. Maiden Name Bruce
15. Birthplace Md.

16 (a) Informant Laurence Nicholson
(b) Address 2147 Division St.

17 (a) Burial (b) Date thereof 3/7/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Balto., City

18 (a) Funeral director A. G. Tebbis
(b) Address 2101 Mc Culloh St.

19 (a) Filed (b) MAR 6 1945 Hunting for Nolting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4/45 1945, at 5-0 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1944 to 3/4/ 1945.
and that I last saw her alive on 3/2 1945.

Immediate cause of death Bronchopneumonia
Due to Hypertension
Due to Diabetes Mellitus

Duration

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Greenlee M. D.
Address [illegible] Sea Date signed 3/5/45

VS 150

626570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9 V 3 D

626570 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1134 N. Stricker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1134 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Ida M. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1886

8. AGE: Years 58 | Months 3 | Days 10 | If less than one day hr. min.

9. Birthplace Northumberland Co. Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Rev. Henry Jessup
13. Birthplace Northumberland Co. Va.

MOTHER
14. Maiden Name Virginia Newman
15. Birthplace Richmond, Va.

16 (a) Informant Edward Jones
(b) Address 1134 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem. Pk. Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lou A. Hall and
(b) Address 1601 Druid Hill Ave.

19 (a) MAR 6 - 1945 (Date received by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1945, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/26 1945 to 3/2 1945 and that I last saw h[illegible] alive on 3/1 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Due to Chronic Myocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. A. Howell M.D.
Address 601 N. Carrollton Ave. Date signed 3/6/45

VS 150

PO G26571 Colored

G26571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G26571 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1914 McCulloh Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1914 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Etta Dougherty

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: James Dougherty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1890

8. AGE: Years 54 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Minnis
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary E. Clark
15. Birthplace Md.

16 (a) Informant Mrs. James Dougherty
(b) Address 1914 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578. W. Biddle St.

19 (a) (Date rec'd by registrar) MAR 6 - 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION P

20. DATE OF DEATH March 4, 1945 19 , at 7:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945, to Mar 4 1945, and that I last saw ... alive on 3-4 1945.

Immediate cause of death: Val Valve Heart Disease — Duration: ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles J. Wedler M. D.
Address 811 Park Ave Date signed 3/6/45

DH-26572m

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. 26572

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5214 Denmore Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5214 Denmore Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore W. Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Delia Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1891

8. AGE: Years	Months	Days	If less than one day
53	4	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Alfred Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Anna. ?
15. Birthplace Md.

16 (a) Informant Mrs. Delia Smith
(b) Address 5214 Denmore Ave.

17 (a) Burial (b) Date thereof 3-7-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St. Williams, Mgr.

19 (a) MAR 6 - 1945 Huntington
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4, 1945, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1944 to March 4 1945
and that I last saw him alive on March 1945

Immediate cause of death: Cerebral Hemorrhage — Duration 1 Day

Due to Hypertension

Due to Renal Failure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Eastman M. D.
Address 503 N. Francis Date signed

X

626573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

V 626573

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important. Please correct age is

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 N. Eutaw St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 N. Eutaw St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: ROSE E. DAUGHERTY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife: Edward Daugherty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1873

8. AGE: Years	Months	Days	If less than one day
71	7	29	hr. min.

9. Birthplace Augusta Co., Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George W. Spiers
13. Birthplace England

MOTHER
14. Maiden Name ? Rogers
15. Birthplace ?

16 (a) Informant Mrs. D. D. Rowe
(b) Address 506 N. Eutaw St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/6/45 (month) (day) (year)
(c) Cemetery or crematory Waynesboro, Va.
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 6 - 1945 (Date of registration) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 5, 1945, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1945 to 3/5 1945.
and that I last saw h[illegible] alive on 3/5 1945.

Immediate cause of death	Duration
Pulmonary edema	1 day
Due to Myocardial insufficiency	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank Lemmon
Address 4004 Liberty Hts Ave Date signed 3/6/45 M. D.

Furnished for Waynesboro

G26574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G26574 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 613 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Tubman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-17-89

8. AGE: Years 55 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Moses Tubman
13. Birthplace Maryland

MOTHER 14. Maiden Name Josephine Cooper
15. Birthplace Maryland

16 (a) Informant Relative
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County Md

18 (a) Funeral director Joseph D. Locke
(b) Address 1304 N. Central Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS MAR 6 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1945, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 14 1944 to March 4 1945, and that I last saw h[illegible] alive on March 4 1945.

Immediate cause of death: Respiratory Failure — Duration
Due to: Respiratory obstruction by metastatic Carcinoma
Due to: Carcinoma of lung

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Manner of injury
23. Signature William J. Dixon
Address Johns Hopkins Hospital 3/4/45

X

G26575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G26575

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every item correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Penna Ave
(c) Hospital or institution:
1600 Blk Penna Ave 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 Brunt St
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Viola Conyer

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. W M

6 (b) Name of husband or wife W M

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 5/12 1899

8. AGE: Years 45 | Months 9 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name —
13. Birthplace

MOTHER
14. Maiden Name Annie Brown
15. Birthplace Va

16 (a) Informant Alice Davis
(b) Address 603 Madison Ave

17 (a) Burial (b) Date thereof 3/8/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Mt

18 (a) Funeral director Geo. H. Kelly
(b) Address 1303 Presstman St

19 (a) MAR 6 - 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1945, at 11 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 3 1945, to March 3 1945, and that I last saw h[illegible] alive on March 3 1945.

Immediate cause of death Cerebral Hemorrhage — Duration .....

Due to ..... — Duration .....

Due to ..... — Duration .....

Other Conditions ..... — Duration .....

(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Julius S. White M. D.
Address 1543 Penna Ave Date signed 3-6-45

VS 2

626576 ✓ 626576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1326 N. Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1326 N. Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Cook Moodie

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	W

6 (b) Name of husband or wife Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/12/1881

8. AGE: Years	Months	Days	If less than one day
63	4	20	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name David Burke
13. Birthplace Md

MOTHER
14. Maiden Name Sara Farahan
15. Birthplace Md

16 (a) Informant Alice Burke
(b) Address 1326 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/2/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. G. Kelso
(b) Address 1303 Priestman St

19 (d) MAR 6 - 1945 Hunting for Williams M.T. (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2/45, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15-1945, to 3/2-1945, and that I last saw h[illegible] alive on 3/2-1945

Immediate cause of death	Duration
Cor pulmonale	
Due to Uremia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Burke Clutts M. D.
Address 1326 N. Mount St Date signed 3/3-45

G26577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93B

Registered No. G26577

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1336 Woodyear st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - 17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1336 Woodyear st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sally Frey Brown

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	A. A.	Widowed

6 (b) Name of husband or wife Clarence E. Frey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept - 1900

8. AGE: Years	Months	Days	If less than one day
44	6		hr. min.

9. Birthplace Balto, Md (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Edward Frazier
13. Birthplace Maryland

MOTHER
14. Maiden Name Kate Jennings
15. Birthplace Maryland

16 (a) Informant Eugene Brown
(b) Address 133 E Woodyear Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/45 (month) (day) (year)
(c) Cemetery or crematory National
Location Md

18 (a) Funeral director Hugh G. Kelly
(b) Address 1305 Pennsylvania Ave

19 (a) MAR 6 - 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3 1945, at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 1945, to 3/3 1945, and that I last saw h alive on 3/3 1945.

Immediate cause of death Myocarditis

Due to

Due to Obesity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
5 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carey C. Johnson M. D.
Address 1802 Pennsylvania Ave Date signed 3/5/45

626578 626578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 153

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3801 Granada
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie Goldman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Aaron
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1910
8. AGE: Years 35 Months Days If less than one day hr. min.
9. Birthplace Atlanta Georgia (Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name Michael Falcon
13. Birthplace Russia

MOTHER
14. Maiden Name Bailey
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-45 (month) (day) (year)
(c) Cemetery or crematory Wash. Bet
Location Wash Bet
18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto
19 (a) (Date rec'd by Registrar) 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5 1945, at 1-8 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/2 1945, to 3/5 1945, and that I last saw he alive on 3/5 1945.

Immediate cause of death Cardio Resp Failure
Due to Emphysema
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature J Simons M. D.
Address Sinai Hospital Date signed 3/7 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26579

G26579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G26579

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. Balto. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 Jackson Square
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph B. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Dora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day hr.	min.
54				

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Cab Driver

11. Industry or business

FATHER
12. Name Abraham
13. Birthplace Russia

MOTHER
14. Maiden Name Leah
15. Birthplace Russia

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phil. Rd. & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) [illegible] for Williams M.D. (Date rec'd by reg.) Registrar

VS-186

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5 1945, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1945 to 3/5 1945, and that I last saw h.im alive on 3/5 1945.

Immediate cause of death	Duration
Cardio-Respiratory failure	
Due to Myocardial insufficiency	
Due to Coronary artery disease.	
Other Conditions Treated and improved	
Pulmonary edema - C.P.C.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: same as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Levitas

Address Sinai Hosp. Date signed 3/5/45 M.D.

For Dr. H. Blue-Wally, by Howard L. Wallerin, M.D.N

626580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

626580 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BELVEDERE & GREEN SPRING AVE
(c) Hospital or institution:
LEVINDALE
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days) 38 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. BELVEDERE & GREEN SPRING AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Solomon Cushnow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Rosie Cushnow

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Morris –
13. Birthplace Poland.

MOTHER 14. Maiden Name Edna –
15. Birthplace Poland.

16 (a) Informant Philip J. Cushnow
(b) Address 3506 White Chapel Road

17 (a) Burial (b) Date thereof 3-6-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory United Hebrew Cem.
Location Washington Blvd.

18 (a) Funeral director Jacob Levin Inc
(b) Address 139 E. Balto. St

19 (a) (Date rec'd by registrar) (b) Arlington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1945, at 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-17- 1942 to 3-5 1945, and that I last saw h[illegible] alive on 3-5 1945.

Immediate cause of death Chr. card. vas. disease
Hypertension, arteriosclerosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Solomon Levin
Address Levindale Date signed 3/5/45

626581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

462

626581

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3825 Cold Spring Lane

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3825 Cold Spring Lane (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Bessie Snowhite

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 59 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Samuel Sokolir

13. Birthplace Russia

MOTHER 14. Maiden Name Rose

15. Birthplace Russia

16 (a) Informant Wm. Snowhite

(b) Address 3825 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-45 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location

18 (a) Funeral director Jace Lewis Inc

(b) Address 143 E. Balto St

19 (a) (Date rec'd by registrar) MAR 6 1945 (b) Hunting for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6- 1945 at 1/4 No M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1944 to 3-6 1945 and that I last saw h er alive on 3/5 1945.

	Duration
Immediate cause of death: Pulmonary edema	1 day
Due to: Carcinoma metastatic of Lung	?
Due to: Metastatic carcinoma of liver	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation 10/23/44

Major findings of operation: edema - Carcinoma of intestines probably metastatic

of autopay:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frank Lemmon M. D.

Address 4004 Eulaw St Hopkins Hosp Date signed 3/6/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26582

G26582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1701 C Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No 817 S. Belnord Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Frank K. Abremski

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Veronica
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1891

8. AGE: Years	Months	Days	If less than one day
53	6	8 10	..... hr. ..... min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Elec. Pump Operator
11. Industry or business City of Baltimore

FATHER
12. Name Konstanty Abremski
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mrs. Veronica Abremski
(b) Address 817 S. Belnord Ave.
17 (a) Burial (b) Date thereof 3-8-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oakland Cem.
Location Balto., Maryland
18 (a) Funeral director John J. Ohuda
(b) Address 2829 Hudson St.
19 (a) MAR 6 - 1945 Huntington W. Cooper, M.D.
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-4- 1945, at 10 30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to .....

Other Condition Multiple fractures, contusions, abrasions, contusions, & bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-4-45 at Balto. Md. 10.45 P.M.
(b) Where did injury occur? 8100 block Eastern Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by automobile

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 3-5-45

G26583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83D

Registered No. G26583

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417½ E. Eutaw St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417½ E. Eutaw St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert F. Riggin Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Josephine Riggin

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 10 1872

8. AGE: Years 72 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Joseph Riggin
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Rebecca Easton
15. Birthplace Baltimore Md.

16 (a) Informant Albert F. Riggin Jr.
(b) Address 417½ E. Eutaw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Hagen & Fleming
(b) Address 1416 Light St.

19 (a) Filed By [illegible] (b) Registrar Huntington Williams M.D.

MAR 6 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1944, to 3/3 1945 and that I last saw h[illegible] alive on 3/3 1945.

Immediate cause of death	Duration
— Hemiplegia	2 days
Due to — Cerebral Hypertension	— 3 mos.
Due to — Arterio Sclerosis.	3 mos.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1779 Bolton St Date signed 3/6/45

X

G26584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 13.1a

Registered No. G26584

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkins Ave.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 435 Overbrook Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Albert Jirsa

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8 - 1892

8. AGE: Years 52 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Guard

11. Industry Fairfield

FATHER
12. Name James Jirsa
13. Birthplace Vienna

MOTHER
14. Maiden Name Mary Sauer
15. Birthplace Germany

16 (a) Informant Mrs Elz. Barranco
(b) Address 435 Overbrook Rd

17 (a) Burial (b) Date thereof 3-7-1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location A.A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1476 Light St.

19 MAR 6 - 1945 (Date rec'd by registrar) (b) Hunting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4 1945, at 7:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1945 to 3/4 1945 and that I last saw h.. alive on 3/4 1945

Immediate cause of death	Duration
Congestive Heart failure	
Due to Hypertensive Cardio-Vascular Renal Disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. E. Carr Jr.
Address St Agnes Hosp. Date signed 3/4/45

VS 150

626585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

626585

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3611 Brehms Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3611 Brehms Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Egan

3 (b) If veteran, name war —

(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 1874

8. AGE: Years	Months	Days	If less than one day
71 70			hr. min.

9. Birthplace Pittsburg Pa
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Michael Kagan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Mc Manus
15. Birthplace Ireland

16 (a) Informant Susie E Quinn
(b) Address 3611 Brehms Lane

17 (a) Burial (b) Date thereof March 10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Calvert Cem
Location Pittsburg Pa

18 (a) Funeral director John C Moran
(b) Address 3800 E Baltimore St

19 (a) MAR 6 - 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5- 1945, at 8 30 A.M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 3-5-45-D

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Items of information should be carefully supplied and the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

626586 BALTIMORE CITY HEALTH DEPARTMENT X 626586

CERTIFICATE OF DEATH 5 1B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Frederick
(c) City or town Middletown
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mr. Lee J. Gaver

3 (b) If veteran, name war None

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary C. Gaver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1864

8. AGE: Years 80 | Months 11 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name Elias Gaver
13. Birthplace Maryland

MOTHER
14. Maiden Name Henrietta Shibetts
15. Birthplace Maryland

16 (a) Informant Son- Mr. Raymond Gaver
(b) Address Middletown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-45 (month) (day) (year)
(c) Cemetery or crematory Lutheran
Location Middletown, Md

18 (a) Funeral director Gladhill Co.
(b) Address Middletown, Md

19 MAR 6 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1945, at 2:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1945, to March 6, 1945, and that I last saw h.im alive on March 6, 1945.

Immediate cause of death	Duration
Terminal bronchopneumonia	
Due to ~~uremia~~ hypostatic Congestion uremia	
Due to Impaction and bilateral pyelonephritis	1 mo
Other Conditions Ca of prostate	1 yr

(Include pregnancy within 3 months of death)

Date of operation Feb 20, 1945

Major findings of operation: CA of prostate

of autopsy: ~~and~~ Intact abdomen

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Vernon H. Harwood M.D.
Address Church Home & Hospital Date signed 3-6-45

626587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

130

626587 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Sparrows Point (If outside city or town limits, write RURAL and give town)
(d) Street No. 7381 Bayfront Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earnest Melsa

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hazel

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 11-28-06

8. AGE: Years 38 | Months 3 | Days 8 | If less than one day hr. min.

9. Birthplace Iowa (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Melsa
13. Birthplace Iowa

MOTHER 14. Maiden Name Gertrude Hahn
15. Birthplace Iowa

16 (a) Informant Record.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-45 (month) (day) (year)
(c) Cemetery or crematory OAK HILL
Location SOLON, IOWA.

18 (a) Funeral director John O. Mikesell
(b) Address 1700 Eastern Ave.

19 (a) (b) Huntington Williams, M.D. Registrar

Filed in Registrar's Office MAR 6 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1945, at 6 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 22 1945 to Mar 6 1945, and that I last saw him alive on Mar 6 1945.

Immediate cause of death Uraemia — Duration

Due to Acute nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Feb. 27, 1945

Major findings of operation: Swollen kidneys

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ross L. McLean

Address J. H. H. Date signed 3-6-45 M.D.

X

G26588 469368

BALTIMORE CITY HEALTH DEPARTMENT X 46a G26588 Registered No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 D
(e) Length of stay in Baltimore (yrs., mos., or days) 12 D

2. USUAL RESIDENCE OF DECEASED:
(a) State S. C. (b) County
(c) City or town Columbia (If outside city or town limits, write RURAL and give town)
(d) Street No. 4913 Main St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin J. Barrett
3 (b) If veteran, name war ✓ 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Eliz. Ryles Barrett
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2-19-85

8. AGE: Years	Months	Days	If less than one day
60	X	15	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation Foreman of Printing office
11. Industry or business

FATHER
12. Name Sam Barrett
13. Birthplace S. C.

MOTHER
14. Maiden Name Young M. E. Knight
15. Birthplace S. C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 9 45 (month) (day) (year)
(c) Cemetery or crematory Elmwood Cem.
Location Columbia S.C.

18 (a) Funeral director John Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) (Date received by Registrar) MAR 6 1945 Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

A

20. DATE OF DEATH March - 6 - 1945, at 3.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-22 1945 to March-6 1945, and that I last saw him alive on March-6 1945;

Immediate cause of death: ? Coronary Occlusion — Duration immediate

Due to (Directly) Carcinoma of Esophagus & Gastroesophageal stricture — 4 years, 10 days

Due to Atelectasis L.L.L. — 10 days

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/26/45

Major findings of operation: Ca of esophagus.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Alan C. Woods M.D.
Address Johns Hopkins Hospital Date signed 3/6/45

VS 150

X

626589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 F

626589 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2605 Grogan Ave.
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2605 Grogan Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Trabert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary M. Trabert
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) April 15, 1880

8. AGE: Years	Months	Days	If less than one day
64	10	17	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name John Trabert
13. Birthplace Germany

MOTHER
14. Maiden Name Elizebeth Furst
15. Birthplace Baltimore Md.

16 (a) Informant Mary M. Trabert
(b) Address 2605 Grogan Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Md.

18 (a) Funeral director John C. Miller Inc.
(b) Address 2435 E. Oliver St.

MAR 6 - 1945 Date rec'd by Registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 19 45, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 19 45, to March 3 19 45 and that I last saw h[illegible] alive on March 3 19 45.

	Duration
Immediate cause of death Carcinoma of Liver	1 year
Due to Cachexia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M. D.
Address 2413 E Monument St Date signed 3/6/45

G26590 12-3

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46B

G26590
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1744. Flet St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Poe.
(b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) ? ? 1892 ?
8. AGE: Years 53 ? Months Days If less than one day hr. min.
9. Birthplace Poland.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Adam Poe.
13. Birthplace Poland.

MOTHER
14. Maiden Name Anna Birdem
15. Birthplace Poland

16 (a) Informant Friends.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross.
Location Baltimore
18 (a) Funeral director Fred W Brazunas
(b) Address 1930 Huntington Ave
19 (Date received by registrar) MAR 6 - 1945 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3.5 1945, at 10 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2.2 - 1945, to 3.5 1945, and that I last saw h[illegible] alive on 3.5 1945.

Immediate cause of death: Lymphosarcoma involving brain,
Due to: stomach, kidney
Due to: and lymphatic system
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Lymphosarcoma

Duration: 4 months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus M.D.
Address Johns Hopkins Hosp Date signed 3/6/45

VS 150

G26591 G26591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1701

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 S Collington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jan Czeslaw Lewandowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace Poland
(Town, county, and State)

10. Usual Occupation Iron Worker

11. Industry or business

FATHER
12. Name Frank Lewandowski
13. Birthplace Poland

MOTHER
14. Maiden Name Stanislawa Owacki
15. Birthplace Poland

16 (a) Informant Stanislawa Marcinczewski
(b) Address 210 S. Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave

19 (a) MAR 6 1945 (Date rec'd by registrar) (b) Returned for Filing M.R. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1945, at 1:15 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 3 1945 2/3/45 at 11 P M.
(b) Where did injury occur? Fleet & Washington Sts
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury pedestrian struck by truck

23. Signature Robert Lee Preston M.D.
Medical Examiner.
Date signed March 4 1945

(over)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83

G26592 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5
(c) Hospital or institution: South Baltimore Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 Church St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tena Koc

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1924

8. AGE: Years	Months	Days	If less than one day
21			hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Koc
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Stec
15. Birthplace Poland

16 (a) Informant John Koc
(b) Address 1623 Church St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross a/co
Location Baltimore

18 (a) Funeral director Fred Wozniewski
(b) Address 930 Fenton Ave

19 (a) (Date rec'd by registrar) Registrar

YS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4 1945, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Epilepsy Idiopathic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.
Date signed 3/5/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A39970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G26593

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1910 Wilhelm
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby "Girl" Brack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-25-45

8. AGE: Years | Months | Days: 6 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Brack
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Cunningham
15. Birthplace Md.

16 (a) Informant records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 6 - 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 6 - 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March - 3 - 1945 at 3 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 - 25 - 1945 to 3 - 3 - 1945 and that I last saw her alive on 3 - 3 - 1945

Immediate cause of death: Prematurity —

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John R. Bunningham
R. Sidney Hess

Address Hopkins Hospital Date signed 3/4/45

VS 150

12569

G26594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G26594

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: University Hosp. 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 824 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Antonio Pombel

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
63	-		..... hr. ..... min.

9. Birthplace ..... (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name .....
13. Birthplace .....

MOTHER
14. Maiden Name .....
15. Birthplace .....

16 (a) Informant .....
(b) Address .....

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory .....
Location JOHN HOPKINS MEDICAL SCHOOL MAR 6 - 1945

18 (a) Funeral director .....
(b) Address .....

19 (a) MAR 6 - 1945 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1945, at 1 30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Robert Lee Fraham M.D.
Medical Examiner.
Date signed Feb 21 1945

X

G266595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 85

Registered No. G266595

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 Bureau St
(c) Hospital or institution: Balto. City Jail
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 E Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James L. Tanner.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Auto mechanic

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location JOHN HOPKINS MEDICAL SCHOOL MAR 6 - 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) MAR 6 - 1945 Hunter Williams, M.D. Registrar
(Date rec'd by registrar)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1945, at 10.15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14/ 1945 to 2/15 1945. and that I last saw h alive on 2/15 1945.

Immediate cause of death Cardiac failure — Duration: unknown

Due to

Due to

Other Conditions Status epilepticus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(c) Means of injury

23. Signature H. Mac Murchy M. D.

Address 801 Bureau St Date signed 2/15/45

1256 X

G26596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G26596 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Hudson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 6 - 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 6 - 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23- 1945, at 10:15 P. M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereof and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Reveley M.D.
Medical Examiner.
Date signed 2-24-45

2566

X

626597

626597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1607 Faith Lane
(c) Hospital or institution:

8-7

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 Faith Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country X

3 (a) **FULL NAME** (Mrs) Winnie Walker Hall

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	col	married

6 (b) Name of husband or wife George 23
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1922

8. AGE: Years	Months	Days	If less than one day
23			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Robt. Edward Walker
13. Birthplace D. C.

MOTHER
14. Maiden Name Georgie Mosley
15. Birthplace Baltimore, Md

16 (a) Informant George Hall
(b) Address 1607 Faith Lane

17 (a) Burial (b) Date thereof 3/7/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location a. a. County Md

18 (a) Funeral director Joseph S. Locke, Jr.
(b) Address 4344 W. Central Ave

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MAR 8 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1945, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-23 1945, to 3-3 1945, and that I last saw h alive on 3-3 1945.

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	Indefinite
Due to Pulmonary Congestion	
(b) Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Edward Fisher M. D.
Address 1612 E. Monument Date signed 3/6/45

626598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

626598 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Halethorpe
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5521 Oregon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA G. VANSANT

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Robert G. Vansant
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1875

8. AGE: Years	Months	Days	If less than one day
70	1	18	hr. min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Shaw
13. Birthplace Md.

MOTHER
14. Maiden Name ? Ray
15. Birthplace Md.

16 (a) Informant Mr. Robert G. Vansant
(b) Address 5521 Oregon Ave., Halethorpe

17 (a) Burial (b) Date thereof 3/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) (b) Huntingtor Williams, M.D.
(Signature of registrar) Registrar

MAR 6 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1945 at 2:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to March 6 1945; and that I last saw him alive on March 5 1945.

Immediate cause of death	Duration
Cerebral thrombosis	1 week
Due to arteriosclerosis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work?
(e) Means of injury

23. Signature Robert L. Mortimer M. D.
Address 270 St Paul Date signed 3/6/45

X

626599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

626593 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4337 Park Heights Ave.
(c) Hospital or institution:

15 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4337 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTEMAS V. CHALK

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Susan B. Chalk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1854

8. AGE: Years	Months	Days	If less than one day
90	7	17	hr. min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)
10. Usual Occupation Retired Painter
11. Industry or business

FATHER
12. Name Chalk
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant J. albert Boyd
(b) Address 4337 Park Hgts. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAR 6 - 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1945, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1945 to March 5 1945, and that I last saw h~~im~~ alive on March 4 1945.

Immediate cause of death Arterio Sclerosis
Cerebral Hemorrhage — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. Benjamin Kadis M. D.
Address 2306 Eutaw Pl Date signed 3-6-45

Huntington Williams, M.D. Baltimore-17-Md ×

G26600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G26600
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood and Greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 1 day
(e) Length of stay in Baltimore (yrs., mos., or days): 1 Year

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County: Baltimore
(c) City or town: Dundalk, 22 (If outside city or town limits, write RURAL and give town)
(d) Street No.: 86 Yorkway (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Ruth H. Lachman (Ruth Hoshour Lachman)

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No.: NONE

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edwin M.

6 (c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): June 17, 1894

8. AGE: Years: 50 Months: 8 Days: 19 If less than one day: ....hr. ....min.

9. Birthplace: Easton, Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: Joshua Josiah W. Hashour
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Daisy L. Ogden
15. Birthplace: Pa.

16 (a) Informant: Mr. Ellis Clark
(b) Address: Easton Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-1945 (month) (day) (year)
(c) Cemetery or crematory: Springhill Cemetery
Location: Easton, Maryland

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 108 W. North Av. (W.F. Wooden-Suc.)

19 (a) MAR 6 1945 (Registrar) (b) ..... Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 1945, at 5:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from on 3/6 1945 to ..... 19....., and that I last saw her alive on 3/6 1945.

Immediate cause of death: Respiratory Failure — Duration: at least 10 years

Due to: Aortic Stenosis

Due to: Rheumatic cardio-vascular disease

Other Conditions: Mitral stenosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Millard T. Trabandt Jr. M.D.
Address: University Hospital Date signed: 3/6/45

Huntington Williams

X Trabandt Jr.

G26601 *

AB-63099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

Registered No. G26601

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4yrs-1mos-9days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Lauterback- or -William Scott

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Clara (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1- 1872

8. AGE: Years	Months	Days	If less than one day
72	11	4	....hr. ....min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name (D) John Lauterback or John Scott
13. Birthplace Germany

MOTHER
14. Maiden Name (D) Catherine
15. Birthplace Germany

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (Date received by registrar MAR 7 - 1945) Signature for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1945, at 12.50 P

21. I certify that death occurred on the date above stated; that I attended deceased from 1-27 1941 to 3-5 1945 and that I last saw him alive on 3-5- 1945

Immediate cause of death	Duration
Cardiac failure	10 days
Due to Arteriosclerotic Cardio-vascular disease.	?
Due to	
Other Conditions Bronchopneumonia	4-5 days.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Aortic stenosis & hemorrhage Cerebral

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hawk E. Dalton M. D.
Address City Hospitals Date signed 3/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

26602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

S 45

Registered No. 26602

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Franklin Square Hospital
(b) Street address Fayette & Calhoun Sts.
(c) Hospital or institution:

From 10-23-44 to 4-5-45

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Laura G. Tyler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Clinton S. Tyler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1865

8. AGE: Years	Months	Days	If less than one day
79	8	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Lt. Col. Seth G. Reed
13. Birthplace United States

MOTHER
14. Maiden Name Sarah J. ?
15. Birthplace United States

16 (a) Informant Mrs. Catherine T. Tyler
(b) Address Washington, D. C.

17 (a) Burial (b) Date thereof March 7, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. W. Pamperau
(b) Address 4510 Liberty Heights Ave.

19 MAR 7 - 1945 Huntington Williams, M.D.
(Date rec'd by Local Reg.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5 1945, at 4:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1932, to 3-5-1945, and that I last saw h alive on 3-4 1945.

Immediate cause of death Carcinoma Uterus Cerv

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

Duration
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Morris Schreiber M. D.
Address 54 S. Fulton Ave Date signed 4-5-45

X

G26603 BALTIMORE CITY HEALTH DEPARTMENT G26603 Registered No. G26603

CERTIFICATE OF DEATH 312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2503 Loyola Southway
(c) Hospital or institution: 15 D
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2503 Loyola Southway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Isaac Scherr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
72 7			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Tailor

FATHER
12. Name Morris Scherr
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie
15. Birthplace Russia

16 (a) Informant Dr Nathan Scherr
(b) Address 2503 Loyola Southway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 MAR 7 - 1945 (Date received by registrar) (b) Huntington Wm Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1945, at 11 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1944 to Mar. 6 1945 and that I last saw him alive on 3/6 1945.

Immediate cause of death Coronary Thrombosis — Duration Fuller

Due to Arteriosclerotic Cardio-

Due to Vascular Renal Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph S. Blum M.D.

Address 126 E. Preston Date signed 3/6/45

G26604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. G26604

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2629 Hampden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irving Eliason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 99.

8. AGE: Years 46 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace D. C. (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER 12. Name Robt. Wm. A. Eliason

13. Birthplace D. C.

MOTHER 14. Maiden Name Annie S.

15. Birthplace D. C.

16 (a) Informant Friends.

(b) Address

17 (a) Removal (b) Date thereof 3/6/45 (month) (day) (year)

(c) Cemetery or crematory Washington

Location D. C.

18 (a) Funeral director H. W. Chambers Co.

(b) Address Washington D. C.

19 (a) Huntington or Williamsport, Md.
(Signature of registrar) Registrar

MAR 7 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5- 1945, at 5 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19- 1945 to 3-5 1945, and that I last saw h[illegible] alive on 3-[illegible] 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Carcinoma of [illegible]	
Due to Stomach Ulcer	4 months
Other Conditions Metastases to lung, diaphragm & adrenal (Including pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy Carcinoma of stomach

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. A. Eliason

Address Johns Hopkins Hosp. Date signed 3/6/45

626605 Ridgely ✓ 626605

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 1312

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Baltimore City
City or town 3719 Chestnut ave - (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mo - Chesholm Rd
Hospital, institution, or street address where death occurred: 1509
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County —
City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 3719 Chesholm Rd. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Emma Jelynn Ridgely

3.(b) Social Security Number

4. Sex: Female | 5. Color or race: white | 6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife George Ridgely -

6.(c) If alive, give age 87 years

7. Birth date of deceased (mo., day, yr.) Sept 12 1859

8. AGE: Years 85 | Months 5 | Days 15 | If less than one day ... hrs. ... min.

9. Birthplace Washington DC (Town, county, and state)

10. Usual occupation House wife

11. Industry or business —

FATHER: 12. Name Charles Crawford
13. Birthplace Md.

MOTHER: 14. Maiden name Ruth Thompson
15. Birthplace Md - KNOCK

16. Interment Mrs Stanley Lamdin
Address 3719 Chestnut ave -

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/9/45 (month) (day) (year)
Cemetery or crematory Laytonsville Cemetery
Location Laytonsville Md
18. Funeral director Purnell E. Gartner
Address Gaithersburg Md.

Filed 3-7-1945 Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 6 1945, at ... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 2-14 1945, to 3-6 1945 and that I last saw h... alive on 3-5-45 19...

Immediate cause of death — DURATION
Arteriosclerotic Cardiac Vascular — 5 yrs
Due to Diabetes — 15 yrs
Due to Chronic myocarditis — 5 yrs
Other conditions Chronic Nephritis — 2 yrs
(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Thos J. Ashford M.D. M. D. or other
Address 1505 Eutaw Heights Balto Date signed 3-6-45

G66606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G66606 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4008 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 3933 Edmondson Ave. (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella R. Knode

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wilbur H. Knode

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 9. 1879

8. AGE: Years 66 | Months 0 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry G. Conway.
13. Birthplace Md.

MOTHER
14. Maiden Name Josephine V. Batory
15. Birthplace Md

16 (a) Informant Wilbur H. Knode
(b) Address 3933 Edmondson Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3/10/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilbur Lord Funeral Home
(b) Address 1217 E. Fayette St

19 MAR 7 - 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1945, at 11:50 A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed March 6 1945

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G26607

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 716 E. 37th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 716 E. 37th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth M. Hay

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband or wife: George Hay
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27th 1867

8. AGE: Years	Months	Days	If less than one day
77	6	8	hr. min.

9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Unknown
13. Birthplace Scotland

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Gladys Hay
(b) Address 716 E. 37th st.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/8/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) MAR 7 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 5th 1945, at 110 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 Mar 1945, to 5 Mar 1945, and that I last saw h[illegible] alive on 5 Mar 1945.

Immediate cause of death	Duration
Lobar Pneumonia	3 Da
Due to Cereb. Hemorrhage	1 yr
Due to arterio sclerosis	8 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Y

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence X at M
(c) Where did injury occur? X (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. Monroe Draper M. D.
Address 3534 Ellerslie Ave Date signed 6 Mar 45

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626608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93-C

Registered No. 626608

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 727 Northern Parkway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 727 Northern Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Dudley Simmons

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1926

8. AGE: Years	Months	Days	If less than one day
19	0	17	hr. min.

9. Birthplace New York, N. Y.
(Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER
12. Name Cameron Simmons
13. Birthplace Netherland West Indies

MOTHER
14. Maiden Name E. Blanche Simmons
15. Birthplace British West Indies

16 (a) Informant Mrs. E. Blanche Simmons
(b) Address 727 Northern Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 7 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4/45, 19..., at 10.39 M

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rheumatic Cardio - vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D.
Medical Examiner.
Date signed 3/5/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6-6609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 6-6609

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2931 West North Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2931 West North Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CLIFTON N. PARDOE

3 (b) If veteran, name war: --

3 (c) Social Security Account No. 218-10-1796

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elsie M. Pardoe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1877

8. AGE: Years 67 | Months 2 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Ship Joiner

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name William Pardoe
13. Birthplace Md.

MOTHER
14. Maiden Name Florence Conway
15. Birthplace Md.

16 (a) Informant Mrs. Elsie M. Pardoe
(b) Address 2931 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/45 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Washington Blvd.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAR 7 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1945 at 3:10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Davis, M.D. Medical Examiner.
Date signed 3/6/45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 626610

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2510 Greenmount Ave.
(c) Hospital or institution: Southern Hospital & Home 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (10 yrs. previous) 1819 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Duff Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: George W. Bowen, Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1854

8. AGE: Years 90 | Months 9 | Days 7 10 | If less than one day ... hr. ... min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name James Duff
13. Birthplace ?

MOTHER
14. Maiden Name Eliza Jane Capprise
15. Birthplace ?

16 (a) Informant Southern Home Records
(b) Address 2510 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

MAR 7 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1945, at 7.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1. 44 to 3-4-45.
and that I last saw h[illegible] alive on 3-4-45 19...

Immediate cause of death	Duration
Chronic Interstitial Nephritis.	10 yrs.
Due to Valvular Disease Heart	15 yrs.
Other Conditions old age	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert C. Blake M. D.
Address Medical Arts Bldg. Date signed

VS 150

Dr. Herbert Blake X

611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G-6611

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 Peach Orchard Lane
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. Turner's Stat. (If outside city or town limits, write RURAL and give town)
(d) Street No. 704 Peach Orchard Lane (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Mae Payne

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-23-1913

8. AGE: Years 31 | Months 9 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Frederick Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Ceaser
13. Birthplace Md.

MOTHER
14. Maiden Name Eva Sanders
15. Birthplace Md.

16 (a) Informant George Payne
(b) Address 704 Peach Orchard Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-45 (month) (day) (year)
(c) Cemetery or crematory Fairview Cem.
Location Frederick Md.

18 (a) Funeral director Edward Geeper
(b) Address 523 N. Carrollton Av.

MAR 7 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2-45 19..., at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1- 1945, to 3-2- 1945, and that I last saw h[illegible] alive on 3-2- 1945.

Immediate cause of death	Duration
Diabetes Mellitus	7
Due to	
Due to	
Other Conditions Intestinal Obstruction (partial) (Include pregnancy within 3 months of death)	4 days

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Broadnax Higgins
Address 2743 Broadway Date signed 3/6/45

VS 150

G26612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8 9a ?

G26612 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County –
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2301 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Raymond Hutchens
3 (b) If veteran, name war No
3 (c) Social Security Account No. ?
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Separated
6 (b) Name of husband or wife Ella R. Hutchens
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) March 16, 1908
8. AGE: Years 36 Months 11 Days 20 If less than one day hr. min.
9. Birthplace Staunton, Va.
(Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business Unemployed

FATHER
12. Name Raymond Hutchens
13. Birthplace Staunton Va

MOTHER
14. Maiden Name Bertha Thomas
15. Birthplace Staunton, Va.

16 (a) Informant Bertha T. Hutchens
(b) Address 7 Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 8-45. (month) (day) (year)
(c) Cemetery or crematory Mount Olivet Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles L. Seguel.
(b) Address 505 N. Monroe St.

19 (a) MAR 7 - 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1945, at 8:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3:00 P.M. 3-5 1945, to 8:20 P.M. 3-5 1945, and that I last saw h[illegible] alive on 3-5 1945.

Immediate cause of death	Duration
Resp. failure	
Due to Pneumococcal meningitis	1 day
Due to Pneumococcus	
Other Conditions Hypotension, Questionably pulmonary tuberculosis otitis media	

(Include pregnancy within 3 months of death)

Date of operation –
Major findings of operation: –
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret A. D. Smith M. D.
Sydenham Hosp Date signed 3-6-45

8 / a

G66613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3D

Registered No. G66613

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1730 Gough Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 Gough Street
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME STELLA WESOLOWSKI - STANISLAWA

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: 7

4. Sex: F
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1895

8. AGE: Years: 50 | Months: | Days: | If less than one day: hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: Housekeeper
11. Industry or business: at Home

FATHER
12. Name: Roman Dziennik
13. Birthplace: Poland

MOTHER
14. Maiden Name: Not Known
15. Birthplace: " " "

16 (a) Informant: John Wesolowski
(b) Address: 1730 Gough St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3 8 45 (month) (day) (year)
(c) Cemetery or crematory: Holy Rosary
Location: Balto Co

18 (a) Funeral director: William Piaskowski
(b) Address: 1612 Eastern Ave

19 (a) (Date received by registrar) MAR 7 1945 Registrar

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4, 1945 at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hypertension & Cardio Vascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: John R Davis M.D.
Medical Examiner.
Date signed 3/8/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G26614

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2031 Division St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2031 Division St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Hughes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Widower

6 (b) Name of husband or wife Laura

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May, 1886

8. AGE: Years	Months	Days	If less than one day
58	10		hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Farm Hand

11. Industry or business

FATHER
12. Name Chas. Hughes
13. Birthplace Md.

MOTHER
14. Maiden Name Martha ?
15. Birthplace Md.

16 (a) Informant Blanche Hughes Johnson
(b) Address 2031 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/45 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Long Green, Md.

18 (a) Funeral director Wm. D. Kelso
(b) Address 1303 Presstman St

MAR 7 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5- 1945; at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-25- 1945 to 3-5- 1945 and that I last saw h[illegible] alive on 3-4 1945.

Immediate cause of death	Duration
Cardio-renal-vascular Disease	2 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George C. Page
Address 1816 N. Mount St. (17) Date signed 3-7-45 M. D.

X

G66615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1610

G66615 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 824
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3/4 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Maryland General Hospital (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Marano

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/5/45

8. AGE: Years | Months | Days | If less than one day: 18 hr. 55 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Charles Marano
13. Birthplace Braunstown, Pa

MOTHER
14. Maiden Name Sarah Capocci
15. Birthplace Italy

16 (a) Informant Charles Marano
(b) Address 1802 N Port St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belgian Rd.

18 (a) Funeral director Frank Dolle Woelfel
(b) Address 52 N. Morley St

19 (a) MAR 7 - 1945 (Filed by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1945, at 5:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1945 to 3/6 1945; and that I last saw him alive on 3/6 1945

Immediate cause of death	Duration
Asphyxia Pallida	3/5/45
Due to Umbilical cord tight around neck	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen G. Magruder, M.D. M. D.
Address 1445 N Gay St. Date signed

VS 150

G66616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G66616 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 736 Eutaw St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 736 Eutaw St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary R. (Rales) Roles
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Joseph Rales
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10 1878

8. AGE: Years 66 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Kelly
13. Birthplace Harford Co

MOTHER
14. Maiden Name Priscilla Conley
15. Birthplace Md

16 (a) Informant Priscilla Parker
(b) Address Same.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 7, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Mr. Wingert

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N Schroeder St

19 (a) MAR 7 - 1945 (Date rec'd by registrar) (b) Registrar

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5-1945 at 3 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20 1945 to 3-5-1945, and that I last saw her alive on 3-4-1945.

Immediate cause of death Chronic Cardio-Vascular Renal disease
Due to Uremia
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 1 year

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. F. Jackson M.D.
Address 600 Madison Ave Date signed 3/6/45

VS 150

G2661.7 ✓ G2661.7

BALTIMORE CITY HEALTH DEPARTMENT 46 F

CERTIFICATE OF DEATH

Registered No. 3698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 Presstman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or da... 15
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Presstman St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Jones

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	colored	married

6 (b) Name of husband or wife Rosie Jones
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Sept 23 1889

8. AGE: Years	Months	Days	If less than one day
55	5	10	___ hr. ___ min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John H. Jones
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margret ?
15. Birthplace Baltimore

16 (a) Informant Rosie Jones
(b) Address 1702 Presstman St

17 (a) Burial (b) Date thereof Mar. 7, '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Annapolis Blvd.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) ... (b) ...
(Date rec'd by registrar) Registrar

MAR 8 194...

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7 1945, at 4.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-26 1945, to 3-7 1945, and that I last saw h... alive on 3-2 1945.

Immediate cause of death	Duration
Carcinoma of Liver	unkn
Due to unknown	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St Date signed 3-6-45

X

6x6618 ✓ 6x6618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day. 13
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 Madison Ave.,
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME Charles H. White

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	married

6 (b) Name of husband or wife Laura White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1899.

8. AGE: Years	Months	Days	If less than one day
46	1	5	hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Charles White.
13. Birthplace St. Mary Co. Md.

MOTHER
14. Maiden Name Addie Barnes.
15. Birthplace St. Mary Co. Md.

16 (a) Informant Mrs. Laura White.
(b) Address 2513 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 7, '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Wilson

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAR 7 - 1945 (Date filed by registrar) Registrar

VS 150

Huntington Williams, Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1945, at 6:15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/3 1945 to 3/3 1945, and that I last saw h.im alive on 3/3 1945.

Immediate cause of death Congestive Heart Failure — Duration .....

Due to ..... — .....

Due to ..... — .....

Other Conditions ..... — .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature J. R. Cooney, Jr.
Address Provident Hospital Date signed 3/6/45 (M. D.)

X

G266619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G266619

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 Orchard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Orchard St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Annie Harriet Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Thomas Robinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/4/1874

8. AGE: Years 70 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace Howard County, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name David Thomas
13. Birthplace Howard County.

MOTHER
14. Maiden Name Mary Henderson
15. Birthplace Howard County

16 (a) Informant Mary Carroll (daughter)
(b) Address 517 Orchard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9, '45 (month) (day) (year)
(c) Cemetery or crematory Asbury Methodist
Location Church, adjoining Church Lot

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 2227 Schroeder St.

MAR 7 1945

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5 1945, at 5:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/2 1945, to 3/5 1945, and that I last saw h alive on 3/5 1945.

Immediate cause of death	Duration
Cardio-vascular-Renal Disease.	17 yr.
Due to Senility	
Due to Hypertension	5 yrs
Other Conditions Arterio-sclerosis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. Louise Jones
Address 1100 Druid Hill Ave Date signed 3/6/45.

VS 8

D26620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

308

D26620 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 308 N. Pearl St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Stone
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Mary Stone
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-97

8. AGE: Years 47 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace U. S. (Town, county, and state)
10. Usual Occupation Plumber.
11. Industry or business

FATHER 12. Name Isaac Stone
13. Birthplace U. S.

MOTHER 14. Maiden Name Livina Watson
15. Birthplace U. S.

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location North Carolina

18 (a) Funeral director L. J. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) MAR 7 - 1945 (b) Name and address of Registrar Huntington White

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22-1945 at 11:28 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16-1945 to 2-22-1945 and that I last saw h[illegible] alive on 2-22-1945

Immediate cause of death [illegible] Shock — Duration

Due to Hemorrhage

Due to Rupture Aortic Aneurysm

Other Conditions Anemia

(Include pregnancy within 3 months of death)
Date of operation 1-15-45
Major findings of operation: Anemia Aneurysm of aorta
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Handelsman M. D.
Address 2-23-45 J. H. Handelsman Attending

VS 150

G26b6 ✓ G26b6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registration No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BELVEDERE + OLD N SPRING AVE
(c) Hospital or institution:
LEVINDALE
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 35

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Joseph Bloom

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lora Bloom
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
55			..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Ret.
11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant Mrs. Lora Bloom
(b) Address 3602 Belvedere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-45 (month) (day) (year)
(c) Cemetery or crematory Greenlawn
Location Park Lawn Inc

18 (a) Funeral director 1439 E. Balt St
(b) Address .....

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 126 MAR 7 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1945, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-19 1945 to 3-6 1945, and that I last saw h[illegible] alive on 3-6 1945.

Immediate cause of death	Duration
Carcinoma of kidney with metastasis to brain	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature H Edmund Kern
Address Levindale Date signed 3/6/45

626622 BALTIMORE CITY HEALTH DEPARTMENT 626622
CERTIFICATE OF DEATH 1221 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayna + Dukeland Ave
(c) Hospital or institution: West Balto Gen Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 33yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto Co
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 N. Payson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOTTIE GREENWALD

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 49 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Hershon –
13. Birthplace Russia

MOTHER
14. Maiden Name Hymne –
15. Birthplace Russia

16 (a) Informant Morris Greenwald
(b) Address 1951 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-45 (month) (day) (year)
(c) Cemetery or crematory United Hebrew Cem
Location Wash. Blvd.

18 (a) Funeral director Jacob Lewis Inc
(b) Address 1439 E. Balto. St

19 (a) (b) Hunterstown Williamsport Md
(Date received) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 5 1945, at 1:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 21 1945 to Mar 5 1945, and that I last saw h e alive on Mar 5 1945.

Immediate cause of death Probably Coronary Occlusion — Duration

Due to Repair of Post Operative Hernia

Due to Post operative hernia for Cholecystectomy

Other Conditions over

(Include pregnancy within 3 months of death)

Date of operation Feb 24 1943

Major findings of operation: Post operative hernia

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James A. Dunkum M. D.
Address West Balto Gen Date signed Mar 7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

626823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 135

626823 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St. & Rutland Ave

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 5016 Penhurst Ave (If rural give location)

(e) Citizen of foreign country? Penhurst (Yes or No)

If yes, name country

3 (a) FULL NAME Isaac Narvasky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ida -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 68 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Ret.

11. Industry or business

FATHER 12. Name Abram

13. Birthplace R.

MOTHER 14. Maiden Name R.

15. Birthplace

16 (a) Informant Sundney Narvasky

(b) Address 5016 Penhurst Ave 3-7-45

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Mt. Sinai

Location

18 (a) Funeral director Jacob Weiss Inc

(b) Address 1439 E. Balt. St

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 7 1945

VS 184

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6/45 19 , at 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1945 to 3/6 1945, and that I last saw him alive on 3/6 1945

Immediate cause of death Myocardial failure

Due to Coronary occlusion, myocardial infarction; coronary sclerosis; missing.

Due to Hypertension - Arteriosclerosis, Heart Disease

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Stanley N. Steinberg

Address Sinai Hospital Date signed 3/6/45

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 66624 Registered No. 1644

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Abington (ABINGDON)
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country —

3 (a) FULL NAME Frank (Stock) Stec

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 7/18/95

8. AGE: Years 49 Yrs | Months 7 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Nicholas Stec

13. Birthplace Austria

MOTHER 14. Maiden Name Barbara Baluch

15. Birthplace Austria

16 (a) Informant Mrs. Bessie Stec

(b) Address Abington Md.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/8/45 (month) (day) (year)

(c) Cemetery or crematory St. Michael's Ukrainian Greek Cath.

Location German Hill Rd. 48th St

18 (a) Funeral director M. F. Lafferty & Sons

(b) Address 1808 Eastern Avenue

19 (a) MAR 7 - 1945 (Date rec'd by registrar) Huntington Mitchell, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1945 at 1 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to Hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 3/6/45 at A. M.

(b) Where did injury occur? 946 S. Eden St.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no

(d) Means of injury? Hanging by rope

23. Signature Robert L. Graham M.D. Medical Examiner.

Date signed March 6 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

626625 626625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3400 N. Charles St
(c) ~~Hospital or institution~~: GREENWAY APT'S.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 D
(e) Length of stay in Baltimore (yrs., ~~mos. or days~~) 65

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Greenway Apts 3401
(If rural, give location) Greenway
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME ELIZABETH WHITEHEAD IRWIN HOYKIN.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: WILLIAM AUGUSTINE HOYKIN (If not living give age ____ years)

7. Birth date of deceased (mo., day, yr.) JULY 31-1853

8. AGE: Years 91 | Months 7 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace NORFOLK, VA.
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER 12. Name HENRY IRWIN
13. Birthplace PENNSYLVANIA

MOTHER 14. Maiden name CORNELIA WHITEHEAD
15. Birthplace NORFOLK, VA.

16 (a) Informant W.A. HOYKIN, JR.
(b) Address RUXTON MD.

17 (a) Removal (b) Date thereof Mar 8 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory ____
Location Norfolk Va

18 (a) Funeral director Kenby W. Jenkins & Sons
(b) Address McCulloh & Orchard Sts.

19 (a) ____ (b) ____
(Date of signature) (Registrar)

VS 3 MAR 7 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5th 1945, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1918, to March 5th 1945, and that I last saw her alive on March 5th 1945.

Immediate cause of death: Accidental fracture of the neck of the left femur with resulting hypostatic congestion & exhaustion — Duration from Feb 14th to time of death

Due to (Secondary) a fall on Feb 14th 1945

Due to Extreme old age

Other Conditions ____
(Include pregnancy within 3 months of death)

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accidental Feb 14 1945
(b) Date of occurrence
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Other apartment While at work? —
(Specify type of place)
(e) Means of injury fall to floor

23. Signature Wm M. Dorsey M. D.
Address Ruxton, Baltimore Md. Date signed March 8th 1945

Approved: Robert Lee Graham M.D. 3/9/45

G26626

469585

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 121

G26626
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 wk.
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Sparrows Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 252 A. Willow Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julius Erdman

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 218-07-7572

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Amelia

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) 12-4-89

8. AGE: Years 55 | Months 3 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace: Poland.
(Town, county, and state)

10. Usual Occupation: Truck helper

11. Industry or business: Gunther Brewing Co.

FATHER
12. Name: Edward Erdman
13. Birthplace: Poland.

MOTHER
14. Maiden Name: Regina Huff
15. Birthplace: Poland.

16. (a) Informant: MRS. AMELIA ERDMAN
(b) Address: WILLOW AVE & NORTH POINT RD

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-45 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) 1945 (Date received by registrar) (b) ... Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 5 1945, at 330 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1945, to March 5 1945, and that I last saw him alive on March 5 1945.

Immediate cause of death: Pulmonary Embolism, Right Lung. — Duration: 20 min

Due to: Phlebothrombosis, (Rt. Femoral) — Duration: 2-4 days

Due to: Ruptured appendix & localized Peritonitis — Duration: 7 days

Other Conditions: 7 day Post operative appendect.
(Include pregnancy within 3 months of death)

Date of operation 2/26/45

Major findings of operation: Necrated, gangrenous appendix & peritonitis

of autopsy: Emboles in Rt Pul. artery

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: W. H. Mueller, M.D.
Address: The Johns Hopkins Hosp. Date signed 3-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Huntington Williams, M.D.

Dallas G26627 BALTIMORE CITY HEALTH DEPARTMENT G26627

CERTIFICATE OF DEATH

Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1305 E. Lexington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 E. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Booker Armstead

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Sep

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Catherine Gay
(b) Address 1305 E Lexington St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 7, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location
18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brasher Ley ave
19 (a) (b)

Date received by registrar MAR 7 1945 Registrar Huntington Williams, M.D.
VS 150

MEDICAL CERTIFICATION

Mar. 4, 1945 — 8:30 P.M.
20. DATE OF DEATH Mar 4 1945 at 8 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1945 to Mar 4 1945 and that I last saw him alive on Feb 26 1945 —

Immediate cause of death: Acute Lobar Pneumonia — Duration: Mar 2 5 1945
Due to Cold
Due to —
Other Conditions none
(Include pregnancy within 3 months of death)
Date of operation no
Major findings of operation: no
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. S. Allen
Address 121 Augusta St Date signed Mar 7-45 M.D.

G266628 G266628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 710 South Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Hudson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
45 44			hr. min.

9. Birthplace (town, county, and state)
10. Usual Occupation Seaman
11. Industry or business

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Maritime Union - C.I.O.
(b) Address Flat + Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/45 (month) (day) (year)
(c) Cemetery or crematory Laurel Hook
Location Laurel Md

18 (a) Funeral director Lilly + Zeigler
(b) Address 403 S. Eutaw St

19 (a) (Date received by registrar) (b) Registrar

MAR 7 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1945, at 2:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Status Epilepticus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-1- at 10 a.m. 2/3
(b) Where did injury occur? In front of 806 S. Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck head on pavement

23. Signature Howard J. Headen M.D.
Medical Examiner.
Date signed 3-2-45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G26629 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Chevy Chase
(If outside city or town limits, write RURAL and give town)
(d) Street No. 437 - Raymond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara K. Peters.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-4-88

8. AGE: Years 57 | Months 5 6 | Days - | If less than one day hr. min. 2

9. Birthplace germany -
(Town, county, and state)

10. Usual Occupation nurse

11. Industry or business

FATHER
12. Name Carl Peters
13. Birthplace germany

MOTHER
14. Maiden Name Anna Loesches
15. Birthplace germany

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (b) Date thereof Mch 8 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Friends Cemetery
Location Sandy Spring Md
Funeral director John C. Mitchell
(b) Address 1960 Sutaw Place

19 (a) 1945 (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6-1945 at 6.35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-14 1944 to 3-6 1945, and that I last saw h- alive on 3-6 1945.

Immediate cause of death: Carcinomatosis & Cachexia — Duration: Months
Due to: Carcinoma of Breast — Duration: Years
Due to:
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Lues III adhesions
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alan G. Woods Jr. M.D.
Address Johns Hopkins Hospital Date signed 3/6/45

X

626630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9 ED

Registered No. 626630

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Cullen

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1847

8. AGE: Years	Months	Days	If less than one day
98	—	—	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation City Water Dept.
11. Industry or business

FATHER
12. Name James Cullen
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Burns
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street-City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 9 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (b) Huntington Maryland

(Date mailed by registrar) MAR 7 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch-5- 1945, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 - 1945 to Mch 5 1945, and that I last saw h~~im~~ alive on Mch-5- 1945

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	6 yrs
Due to	
Other Conditions Arterio-Sclerosis	10 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Wall M. D.
Address 1631 E North Ave Date signed Mch-6-45

X

G26631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G26631

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 N. Fulton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William J. O'Brien

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28-1886

8. AGE: Years	Months	Days	If less than one day
58	8	11	hr. min.

9. Birthplace Baltimore md
(Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name Michael O. O'Brien
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Falvey
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Nathenia Inscoe
(b) Address 1312 N. Fulton Ave

17 (a) Burial (b) Date thereof 3/8/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto md

18 (a) Funeral director H C Brannigan Sons
(b) Address 2924 Edmondson Ave

19 (a) MAR 7 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by Bureau) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 6 1945, at 3.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 27 1944, to Mar. 6 1945, and that I last saw him alive on March 1945.

Immediate cause of death	Duration
Pneumonia Thrombosis	3/6/45
Due to	
Due to Chr. Myocarditis	1942
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James Brown M.D.
Address 1663 W Mont St. Date signed 3/6/45

G26632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 113B

Registered No. G26632

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Spring Ave & Belvedere
(c) Hospital or institution: Levendale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto (b) County Md.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerome Sachs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife widower

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years	Months	Days	If less than one day
85			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Jeane Sachs
(b) Address 411 S. Highland Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location Mt German Hill Rd.

18 (a) Funeral director Jack Levin Inc
(b) Address 1429 E. Baltimore St

19 (a) (Filed by registrar) (b) Huntington Williams, M.D. Registrar

MAR 7 - 1945

VS 1M

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1945, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-3 1936, to 3-6 1945, and that I last saw him alive on 3-6 1945.

Immediate cause of death	Duration
Diabetes Mellitus	
Ca. pulmonary tbc	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Edmund Levin MD

Address Levendale Date signed 3/6/45

X

G26633

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1153

G26633
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Newport News (If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 12th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elsie Cosby

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Married

6 (b) Name of husband or wife Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-5-10

8. AGE: Years	Months	Days	If less than one day
34	11 mo.	1	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Housemaid
11. Industry or business

FATHER 12. Name William Scott
13. Birthplace ? ?

MOTHER 14. Maiden Name Frances Brown
15. Birthplace ? ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-7-45 (month) (day) (year)
(c) Cemetery or crematory Holly Grove
Location Newport News, Va.

18 (a) Funeral director James A Sayles
(b) Address 142 W. Kirk St Huntington Station, Md.

19 (a) MAR 7 - 1945 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1945, at 11:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 3 1945 to Mar 6 1945, and that I last saw her alive on Mar 6 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Disseminated Lupus Erythematosus	6 mo
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Manner of injury
23. Signature William J. Dippe
Address Johns Hopkins Hospital 3/7/45 (Official title)

X

6634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8/a

Registered No. 6634

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~###~~
(c) Hospital or institution: Sydenham Hosp. 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Md~~ (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 Madison Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F.

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Seperated 20 yrs

6 (b) Name of husband or wife: Houston Kinney

6 (c) If alive, give age 50? years

7. Birth date of deceased (mo., day, yr.) July 4, 1894

8. AGE: Years 50 | Months 49 | Days 7 | If less than one day: hr. 4 min.

9. Birthplace Stafford Co. Virginia
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Tom Smith.
13. Birthplace ? Southern states

MOTHER
14. Maiden Name Susan Barnes Smith
15. Birthplace Monassas Co. Virginia

16 (a) Informant Sister, Kate Smith Jones
(b) Address 202 Beechwood St-Princess Anne Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 7 - 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 7 - 1945 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-8 1945, at 2:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7 1945, to 2-8 1945, and that I last saw her alive on 2-8-~~7~~ 1945.

Immediate cause of death Respiratory failure

Due to Pneumococcus meningitis

Due to Pneumococcus

Other Conditions Heart failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. D. Smith M. D.
Address Sydenham Hosp Date signed 2-9-45

2073 X

626635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157 B

626635 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1838 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Edward Lively

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/28/45.

8. AGE: Years	Months	Days	If less than one day
		1.	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Infant.

11. Industry or business

FATHER
12. Name Roland Lively.
13. Birthplace West Virginia

MOTHER
14. Maiden Name Violet Gregory.
15. Birthplace Ohio.

16 (a) Informant Mother
(b) Address 1838 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-45 (month) (day) (year)
(c) Cemetery or crematory Carlin's
Location Balto Md

18 (a) Funeral director Geo A Epley
(b) Address Fulton & Fayette

19 MAR 7 – 1945 (Date rec'd by registrar) (b) Interment Baltimore, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1 1945, at 10 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 1945 to 3/1 1945, and that I last saw him alive on 3/1 1945.

Immediate cause of death: Meningitis ?

Duration: 8 hrs.

Due to Meningocele ? Spina bifida

Due to Developmental defect.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Helpenger M. D.
Address Mercy Hosp. Date signed 3/1/45.

VS 150

G66636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G66636
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
Since 3/3/45-11:00 A.M.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
Since 3/3/45-11:00 A.M.
(e) Length of stay in Baltimore (yrs., mos., or days) Life
(except while in Marine Corps)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
Street:
(c) ~~XXXXXXXX~~ 4211 Connecticut Ave.
(If outside city or town limits, write RURAL and give town)
City:
(d) ~~XXXXXX~~ Baltimore
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANDREW ALOYSIUS WIEGARD - Assigned AES 12-Turner Field,Quantico,Va.

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marie Foley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/17/1922

8. AGE: Years	Months	Days	If less than one day
22	5	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Sgt.
11. Industry or business U.S.Marine Corps

FATHER
12. Name George Wiegard
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ida ?
15. Birthplace Germany

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.
18 (a) Funeral director Sanger & Finley
(b) Address Fulton & Fayette
MAR 7 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH March 3, 1945 at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 3, 1945, to March 3, 1945, and that I last saw h im alive on March 3, 1945.

	Duration
Immediate cause of death: Diabetic coma and acidosis	Sev.hrs.
Due to Diabetes mellitus	Unk.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Benjamin F Jones M. D.
Address Baltimore, Md. Date signed 3/5/45

USMC-59568 X

[redacted] G26637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

G26637 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5528 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Belle Buechman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) Jan. 19 - 1930

8. AGE: Years 15 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace Balto - Md.
(Town, county and state)

10. Usual Occupation at school

11. Industry or business

FATHER
12. Name John H. Buechman
13. Birthplace Balto - Md

MOTHER
14. Maiden Name Lillian Corkran
15. Birthplace Balto Md

16 (a) Informant Mr. John H. Buechman
(b) Address 5528 Belair Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 530 E Lanvale St

19 (a) MAR 7 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1945, at 4 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-6-45 at M.
(b) Where did injury occur? 5528 Belair Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Inhaled illuminating gas

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed March 7 1945.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626638

626638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 da

(e) Length of stay in Baltimore (yrs., mos., or days) 18 da

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 13 (If outside city or town limits, write RURAL and give town)

(d) Street No. 1103 N. Montford Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME John Louis DeVaut

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/17/45

8. AGE: Years	Months	Days	If less than one day
18 da	0	18	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John Wm. DeVaut

13. Birthplace Balto. Md.

MOTHER

14. Maiden Name Marie Jeselin

15. Birthplace Balto. Md.

16 (a) Informant Marie DeVaut

(b) Address 1103 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 8/45 (month) (day) (year)

(c) Cemetery or crematory Park Hill Cem.

Location Baltimore Md.

18 (a) Funeral director John A. Miller

(b) Address 933 Gilmor St.

19 (a) MAR 7 - 1945 (Date received by Registrar) (b) Arlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7 19 45 at 5:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20 19 45 to 3/7 19 45.

and that I last saw him alive on 3/6 19 45.

Immediate cause of death

Due to general cachexia

Due to premature

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Louis J. Pratt, M.D.

Address St. Joseph's Hosp. Date signed 3/7/45

VS 150

G26633 G26633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Ida
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 N. Montford Ave (If rural, give location)
(e) Citizen of foreign country? Italy (Yes or No)
If yes, name country

3 (a) FULL NAME Malvina Callela

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife John Callela

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) 2/15/79

8. AGE: Years 66 Months - Days 23 If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Giampola

13. Birthplace Italy

MOTHER 14. Maiden Name Not known

15. Birthplace Not known

16 (a) Informant John Callela

(b) Address 502 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 10/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd.

18 (a) Funeral director John B. Miller

(b) Address 2334 Jefferson St.

19 (a) (Date rec'd by registrar) (b) Registrar

Vs 1180 R 7 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1945, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1945 to 3/6 1945. and that I last saw h[illegible] alive on 3/6 1945

Immediate cause of death Cerebral hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis J. Tratt, Jr. M.D.

Address St. Joseph's Hosp. Date signed 3/6/45

626640

BALTIMORE CITY HEALTH DEPARTMENT X 626640 Registered No.

CERTIFICATE OF DEATH 93c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Linden Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil
(c) City or town Perryville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Edward Rapposelli

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business Ice

FATHER
12. Name Unknown
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Mrs. E. L. Hanchey
(b) Address Perryville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10, 1945 (month) (day) (year)
(c) Cemetery or crematory
Location Perryville, Md.

18 (a) Funeral director Wm. A. Patterson & Son
(b) Address Perryville, Md.

19 (a) MAR 7 1945 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7 1945 at 1 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14 1945 to 3/7 1945; and that I last saw h[illegible] alive on 3/7 1945.

Immediate cause of death	Duration
Pulmonary Infarction	
Due to Auricular Fibrillation	
Due to Rheumatic C.V. Disease	20 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strober M. D.
Address Md. Genl. Hospital Date signed 3/9/45

X

G26641 Ibbotson G26641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

1. PLACE OF DEATH: 818
(a) Baltimore City, Maryland
(b) Street address 818 Northern Pkwy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No 818 Northern Pkwy.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Alma A. Ibbotson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex female | 5. Color or race colrite | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Ernest M.
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 12/17/96

8. AGE: Years 48 | Months 2 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Storay Creek, Comm.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John A. Anderson
13. Birthplace Sweden

MOTHER 14. Maiden Name Anna O. Anderson
15. Birthplace Sweden

16 (a) Informant Ernest M. Ibbotson
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/45 (month) (day) (year)
(c) Cemetery or crematory Montevesa ST.
Location Brooklyn, Maryland

18 (a) Funeral director Henry W. Jenkins & Sons
(b) Address McCulloh & Orchard Sts

19 (a) (Date rec'd by registrar) (b) Huntington Hill Registrar, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1945, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944, to March 7 1945, and that I last saw her alive on March 2 1945.

Immediate cause of death	Duration
Heart failure	
Due to generalized carcinomatosis	
Due to Malignant breast tumor removed April 1944	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operation Malignant adenocarcinoma, Rt. breast Apr. 1944
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charlotte M. Carthy M. D.
Address 101 Read St. Baltimore 1 Date signed Mar. 7, 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26642 — Ponitz G26642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1210

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost of age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2139 Homewood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2139 Homewood Ave. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Cecelia H Ponitz

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Geo. F. Ponitz
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 64 | Months — | Days — | If less than one day ..... hr, ... min.

9. Birthplace York. Pa. (Town, county, and state)

10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John R. Crafton
13. Birthplace North Carolina

MOTHER
14. Maiden Name S. Pigmane
15. Birthplace unknown

16 (a) Informant Miss Helen Ponitz
(b) Address 2139 Homewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/45 (month, day, year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Mary M. Stufflebeem
(b) Address 5[illegible] Edmondson Ave.

19 (a) MAR 7 - 1945 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5/1945, at 8 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20, 1944 to March 5, 1945, and that I last saw her alive on March 2, 1945.

Immediate cause of death	Duration
Hypertensive Cardiovascular Renal Disease.	2 years
Due to Generalized Arteriosclerosis.	
Due to	
Other Conditions Hemiplegia	Nov. 1944

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature Samuel B. Hyde
Address 1331 E. North Ave. Date signed 3-5-45. M.D.

G26643 ✓ G26643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town San Fernando
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3638 Circular Rd
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Trinidad

3 (a) FULL NAME Pieter Paget Pickering

3 (b) If veteran, name war W
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-24-71

8. AGE: Years 73 | Months 8 | Days 7 | If less than one day hr. min.

9. Birthplace Trinidad
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Simpson Pickering
13. Birthplace Trinidad

MOTHER
14. Maiden Name Charlotte Howe
15. Birthplace Trinidad

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3/8/45
(Burial, ~~cremation or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto. - Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 E. Saratoga St

MAR 8 - 1945 Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1945 at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26 1944 to Mar. 1 1945 and that I last saw him alive on Mar. 1 1945

Immediate cause of death	Duration
CORONARY THROMBOSIS?	Immediate 3 days
Cerebral Embolism ?	
Due to Bronchopneumonia	
Due to	
Other Conditions Carcinoma of Hard Palate (Include pregnancy within 3 months of death)	1 Year

Date of operation 2/12/45
Major findings of operation: Carcinoma of Palate Mouth
of autopsy: None Obtained.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Alan C. Woods Jr.
Address Johns Hopkins Hosp. Date signed 3/6/45 M.D.

G26644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G26644

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1513 Lockwood Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 Lockwood Rd
(if rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles G. Norris

3 (b) If veteran, name war W
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married
6 (b) Name of ~~husband or~~ wife: Matilda
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 11th 1887
8. AGE: Years 57 | Months 3 | Days 24 | If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Supply Officer
11. Industry or business Maritime Commission

FATHER
12. Name James T. Norris
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Frederick
15. Birthplace Balto. Md.

16 (a) Informant Matilda Norris
(b) Address 513 Lockwood Rd.

17 (a) Burial (b) Date thereof 3/8/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 MAR 8 - 1945 (b) Twitington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 5th 1945, at 9.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1944 to March 5 1945. and that I last saw h~~im~~ alive on March 5 1945.

	Duration
Immediate cause of death: Carcinoma of Stomach, Liver and Intestines	1 Year
Due to	
Due to	
Other Conditions Cachexia and metastasis (Include pregnancy within 3 months of death)	15 Days

Date of operation January 15, 1945
Major findings of operation Carcinoma of Esophagus, Stomach, Intestines and Liver
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Albert Rosenberg M. D.
Address 2025 E North Ave Date signed 3/6/45

626645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

626645
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3106 Chesley Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 Chesley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna May Miller

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Wh	M

6 (b) Name of husband or wife George J. Miller
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) June 3, 1883

8. AGE: Years	Months	Days	If less than one day
61	9	4	hr. min.

9. Birthplace Williamsport, Penna
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At home

FATHER
12. Name Ellis H. Hyman
13. Birthplace Jersey Shore, Pa.

MOTHER
14. Maiden Name Margaret Ellen Stahley
15. Birthplace Penna.

16 (a) Informant George J. Miller
(b) Address 3106 Chesley Ave.

17 (a) Removal (b) Date thereof 3/10/45
(~~Burial, cremation, or~~ removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Wildwood
Location Williamsport Pa.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

MAR 8 - 1945 (by) Huntington Williams, Md.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 7 1945, at 9.50a M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 5 1945, to Mar 7 1945, and that I last saw h er alive on Mar 7 1945.

Immediate cause of death	Duration
Myocardial disease	2 yrs.
Due to Diabetis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Wilkinson
A. L. Wilkinson, M. D.
Address 5713 Bel Air Rd. Date signed 3-7-45

6646 BALTIMORE CITY HEALTH DEPARTMENT 94B Registered No. 6646

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1515 Bush St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 Bush St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George R Parks

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Anna L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 22, 1878

8. AGE: Years 67 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Nebraska (Town, county, and state)

10. Usual Occupation Drill Press Man

11. Industry or business US Steel Corp

FATHER 12. Name James L Parks
13. Birthplace England

MOTHER 14. Maiden Name Lydia B Wilson
15. Birthplace Baltimore Md

16 (a) Informant Mrs Edna Duffendall
(b) Address 1515 Bush St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/45 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Wilson & Son Inc
(b) Address 1217 St Paul St

19 (a) (Date received by registrar) MAR 8 1945 (Registrar) Kathryn Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1944 to Mch 6 1945
and that I last saw h alive on 19

Immediate cause of death: Angina Pectoris — Duration 4 mos

Due to Arteriosclerosis — 6 mos

Due to Arteriosclerosis

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard Dann M.D.
Address 1217 St Paul St Date signed 3/7/45

VS 150

G26647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73D

Registered No. G26647

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - 23
(If outside city or town limits, write RURAL and give town)
(d) Street No. 21 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore McGill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1944

8. AGE: Years	Months	Days	If less than one day
—	2½	11 —	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Walter L. McGill
13. Birthplace Atlanta Ga

MOTHER
14. Maiden Name Mary V. Halstead
15. Birthplace Frederick, Md.

16 (a) Informant Hosp. Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 7 - 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 8 - 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1945 at 3:30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1945 to 3/3 1945. and that I last saw h/e alive on 3/3 1945.

Immediate cause of death — Duration
Respiratory embarrassment — 1 day
Due to atelectasis — 6 hrs.
[redacted] anemia — " "

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Lane

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Monk M. D.
Address Univ. Hosp. Date signed 3/7/45

VS 150 a

T 2374 X

626648 ✓ 626648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully prepared. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 861 W Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 861 W Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza Patterson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Calvert Co Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name Hannah Wilson

15. Birthplace

16 (a) Informant William J. Patterson
(b) Address 861 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 9-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location a.a. co. md

18 (a) Funeral director James A Hayes
(b) Address 142 W Fell

19 (a) (Date rec'd by registrar) MAR 8 1945 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5 1945 at 2:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1945 to 3-5 1945 and that I last saw h[illegible] alive on 3-1 1945.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Arteriosclerosis 1 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Arnett Jones M. D.
Address 55-7 Wolfe St Date signed 3-7-45

G26649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G26649 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Louch Balto. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 3003 Thrasher Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mozella Trent

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years 39 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Winston Salem, N.C.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Smith
13. Birthplace N.C.

MOTHER
14. Maiden Name Della ——
15. Birthplace Va.

16 (a) Informant Arthur Trent
(b) Address 3003 Trashers Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/45 (month) (day) (year)
(c) Cemetery or crematory Mt Cabvery
Location a.a. co Md

18 (a) Funeral director James A Hayes
(b) Address 142 W Fiel St

19 (a) MAR 8 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1945 at 10 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Chronic Myocardial Degeneration

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D.
Medical Examiner.
Date signed 3-6-45

VS 151

666650 ✓ 666650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 841 Hoffman
(c) Hospital or institution: ✓ 1417

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1924 Madison (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Parker

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife
6 (c) If alive, [illegible] years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 69 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name John Atkins
13. Birthplace Md

MOTHER 14. Maiden Name Emerson
15. Birthplace

16 (a) Informant Mabel Lusk
(b) Address 906 Tyson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 8, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bloomsbury Ave

19 MAR 8 - 1945 (b) Huntington Williams Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/4/45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/16/45 3/4/45 19 , and that I last saw him alive on 3/4/45.

Immediate cause of death (a) Cerebral Hemorrhage — Duration 6 days
Due to (b) Senile Arteriosclerosis
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. Tolbert M. D.
Address 124 Madison Date signed 3/6/45

G26634 ✓ G26634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1439 E. Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1439 E. Monument St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Perry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore MD (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Edward Perry
13. Birthplace West, Va

MOTHER
14. Maiden Name Anna Jolory
15. Birthplace Vena MD

16 (a) Informant George Perry Brother
(b) Address 121 S Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 9 '45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

19 MAR 8 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 5 1945, at 3:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1945, to Mar 5 1945, and that I last saw h— alive on Mar 5 1945

Immediate cause of death: General Carcinomatosis — Duration 3 mos.
Due to: Hemorrhage of Stomach — 1 mon.
Due to: Carcinoma of Stomach — 1 yr.
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm L. Perry M.D.
Address 1420 E. Chase Date signed 3-7-45

VS 150

66603 Diary ✓ 66603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1305 E. Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 E. Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Charles Sampson

3/4/45

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-4-1861

8. AGE: Years	Months	Days	If less than one day hr.	min.
84				

9. Birthplace Queen Ann, Md. (Town, county, and state)
10. Usual Occupation Unemployed.
11. Industry or business

FATHER
12. Name George Sampson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Brown
15. Birthplace Md.

16 (a) Informant George W. Sampson
(b) Address 1603 E. Madison St

17 (a) Burial (b) Date thereof Mar. 8, 1945 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy J. Wilson
(b) Address 1000 Brantley Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 8 1945 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 4 1945 at 4A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1945 to Mar 4 1945 and that I last saw h. alive on Mar 4 1945

Immediate cause of death Pulmonary edema — Duration 2 Days

Due to Chr. Nephritis

Due to Arterio-Sclerosis

Due to Chr. myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. L. Berry M. D.
Address 1420 E. Chase Date signed Mar 5. 45

666633 Dr. Pursell

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

V 666633 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13 N. Caroline st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 N. Caroline st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23 1893

8. AGE: Years 51 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace Aberdeen, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Solomon Stansbury
13. Birthplace md

MOTHER
14. Maiden Name Mary Hartso
15. Birthplace Md

16 (a) Informant Charles Jones
(b) Address 13 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 10 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bradley Ave

19 (a) MAR 8 – 1945 (Date received by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6th 1945, at 4:33 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2-1945, to 3-6-1945, and that I last saw h[illegible] alive on 3-5-1945.

Immediate cause of death	Duration
Carcinoma of colon	
Due to —	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1422 E. Chase St. Date signed 3-7-45

G266654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G266654 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3101 McElderry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3101 McElderry Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Amelia Good

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife James H. Good
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1880

8. AGE: Years	Months	Days	If less than one day
64yrs.	7	21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Houdwife
11. Industry or business

FATHER
12. Name Edward Johnson
13. Birthplace unknown

MOTHER
14. Maiden Name Margaret Hofstetter
15. Birthplace unknown

16 (a) Informant Mrs. Evelyn Peterka
(b) Address Hanover, Maryland.

17 (a) Entombment (b) Date thereof 3/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Mausoleum
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) MAR 8 - 1945 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1945, at 8 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Mar 7 1945 and that I last saw her alive on 3/7 1945.

Immediate cause of death: Carcinoma of Gall Bladder — Duration 5 months

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation Oct. 1, 1944
Major findings of operation: as above
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sol Smith
Address 1223 E. North Ave Date signed 3/7/45
M D

Balto 2, Md X

VS 150

G26655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G26655 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 945 W. Lexington

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 945 W. Lexington St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Robert R. Summerville

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Red

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28 1907

8. AGE: Years 37 Months 10 Days 5 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER 12. Name William Summerville

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Emma Henson

15. Birthplace Denton, Md.

16 (a) Informant Emma Summerville

(b) Address 1125 W. Saratoga

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 8, '45 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion.

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Md Registrar

MAR 8 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-3 1945 at 9:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15 1945 to 3-3 1945 and that I last saw him alive on 3-3 1945

Immediate cause of death Bronchio-pneumonia — Duration 2 wks

Due to

Due to

Other Conditions hypertensive cardio-renal disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature R. Rayner Browne M.D.

Address 1500 E. Madison St. Date signed 3/7

Rayner Browne 107

626656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

626656 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1931 E. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Elmer B. Worth

3 (b) If veteran, name war —

3 (c) Social Security Account No. 516

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 13 1869

8. AGE: Years 75 | Months 5 | Days 23 | If less than one day .....hr. .....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name John B. Worth
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Virginia Weissy
15. Birthplace Balto. Md.

16 (a) Informant Elizabeth L. Wouth
(b) Address 1931 E. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/45 (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location Frederick Md.

18 (a) Funeral director M. W. E. Dipple's Sons
(b) Address Lombard & Ann Sts.

19. MAR 8 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1945, at 4:15 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereof and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature C. P. Vulpinate M.D.
Medical Examiner.
Date signed 3/10/45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

26657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

626657

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2000 W. FAYETT St
(c) Hospital or ~~institution~~: BON SECOUR
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO
(c) City or town HALETHROPE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4608 POPALAR AV. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Messer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, ~~widowed~~, or ~~divorced~~ M

6 (b) Name of husband or wife HENRY P.

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) MAY 16-1886

8. AGE: Years 58 | Months 9 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace NEW YORK. (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name CHAS GOECKLER
13. Birthplace NEW YORK

MOTHER
14. Maiden Name MARTHA PHEIFFER
15. Birthplace PENNA-

16 (a) Informant HENRY P MESSER (HUSBAND)
(b) Address 4608 POPALAR AV.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/10/45 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR RD

18 (a) Funeral director JOHN R KENNY
(b) Address 1242 LEEDS TER HALETHROPE 27

19 (a) Date received by Local Registrar MAR 8 - 1945 (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1945, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1945 to 3/6 1945 and that I last saw h[er] alive on 3/6 1945

	Duration
Immediate cause of death: Acute Congestive Failure	1 day
Due to: Hypertensive C.V.D.	?
Due to:	
Other Conditions: Pleural & Peri - cardial effusion - ascites.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Terminal Hypostatic Pneumonia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. F. L. Stickel M. D.

Address Res. Lenox Hosp. Date signed 3/6/45.

626658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. 626658

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hosp. 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 W. Barre St
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Inez Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 27 1907

8. AGE: Years	Months	Days	If less than one day
37 30	4	18	...hr. ...min.

9. Birthplace Gastonia N.C
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Agnus
13. Birthplace S.C.

MOTHER
14. Maiden Name Hattie Carter
15. Birthplace S.C.

16 (a) Informant Hattie Agnus
(b) Address 522 W Barre St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/45 (month) (day) (year)
(c) Cemetery or crematory McCullough
Location S. A. & M Rd

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 MAR 8 - 1945 (Date rec'd by Reg.) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1945, at 9 20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of Abdomen & Chest

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 5 1945 8 15 A.M.
(b) Where did injury occur? 602 W. Barre St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shot

23. Signature Robert Lee Fratcher M.D.
Medical Examiner.
Date signed March 5 1945

VS 151

26659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G26659

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 763 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Boyd Laughlin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/8/1886

8. AGE: Years	Months	Days	If less than one day
58	6	28	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business "

FATHER
12. Name William Laughlin
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Margaret E. Dipples
15. Birthplace Balto Md.

16 (a) Informant Mrs. Jennie Leamon
(b) Address 5513 Harrington Ave.

17 (a) Burial (b) Date thereof 3/9/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or ~~cemetery~~ Western Cemetery
Location Edmondson Ave.

18 (a) Funeral director Wilbur W. Sherwood Inc.
(b) Address 4130 Edmondson Ave. Huntington Williams, M.D.

19 (a) MAR 8 - 1945 (b) Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1945, at 3:45 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. L. Lubinski M.D.
Medical Examiner.
Date signed 3/7/45

VS 151

Cause of death clearly and legibly. Physician: please write the

626660 626660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY. Every question must be answered. Use ink. Do not use pencil. Do not abbreviate. Where there is no entry, write NONE. Be sure to answer all questions. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address RAYNER + DUKELAND AVES.
(c) Hospital or institution:
WEST BALT. GEN. HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
City or town BALTIMORE MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 312 W. CAMDEN ST. NEW JOYCE HOTEL
(If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD HUGHSON

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 2 1898

8. AGE: Years	Months	Days	If less than one day
47	1	4	hr. min.

9. Birthplace MICHIGAN (Town, county, and state)
10. Usual Occupation TRUCK DRIVER
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace MICHIGAN

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace MICHIGAN

16 (a) Informant FRED JOHNSON (FRIEND)
(b) Address 312 W. CAMDEN ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 8/45 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD
18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST.
19 (a) MAR 8 (Date rec'd by registrar) (b) 1945

Huntington Whitaker

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1945 at 4A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3 1945 to 3/6 1945 and that I last saw h. l. m. alive on 3/6 1945

Immediate cause of death CONGESTIVE HEART FAILURE — Duration

Due to ARTERIO SCLEROTIC HEART DISEASE.

Due to

Other Conditions POSSIBLE MYOCARDIAL INFARCTION
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: 1) MYOCARDIAL INFARCTION 2) CONGESTIVE HT. FAILURE 3) ARTERIO SCLEROSIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. M. Liebenfeld M. D.
Address West Balt Gen Hosp Date signed 3/6/45

G66661 G66661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3919 E. Fait Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Becker.

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 214-03-4260

4. Sex: Male

5. Color or race: White.

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Alice BECKER

6 (c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) 5.25.15

8. AGE: Years 29 | Months 9 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace BALTO. Md. (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name Howard Becker
13. Birthplace Md.

MOTHER
14. Maiden Name Frances. Slaskowiak
15. Birthplace Md.

16 (a) Informant Rec'nar.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 9-45 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave.

18 (a) Funeral director Lilyand Zeiler INC.
(b) Address 403 S. Wolfe St.

19 (a) MAR 8 - 1945 (Date rec'd by registrar)

Registrar Huntington Williams, M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Use a typewriter if possible. Do not abbreviate or use ditto marks. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1945, at 1201 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 1944 to March 6 1945, and that I last saw him alive on March 6 1945.

	Duration
Immediate cause of death: Miliary tbc	
Due to: Tbc of rt. lung	3 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Haydelman M.D.
Address JHH Date signed 3-7-45

X

G26662 G26662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 40 E. Hamburg St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 40 E. Hamburg St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret E. Neveker

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
? 73			hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Neveker
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Elisa Greenwood
15. Birthplace Baltimore Md.

16 (a) Informant John Snyder
(b) Address 40 E. Hamburg St.

17 (a) Burial (b) Date thereof 3-9-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) Mar 8 1945 Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1945, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1945 to March 6 1945, and that I last saw h alive on 1945.

Immediate cause of death	Duration
Carcinoma Head of Pancreas	
Due to —	
Due to	

Other conditions Arteriosclerosis Hypostasis Myocarditis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John E. Schneck
Address 1337 S. Clinton St. Date signed 3/7/45

X

G26663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

460 Registered No. G26663

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Grant Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3104 Rosalie Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Andrew C.R. Seemans

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Susan H. Seemans

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 30-1868

8. AGE: Years	Months	Days	If less than one day
76	11 10	6	hr. min.

9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation Carpenter (ret.)
11. Industry or business

FATHER
12. Name John L. Seemans
13. Birthplace Del.

MOTHER
14. Maiden Name Mary Thomas
15. Birthplace Del.

16 (a) Informant W. M. Parkhurst
(b) Address 3104 Rosalie Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore Md.

18 (a) Funeral director L. J. Rucker
(b) Address 530 S. Gaylord St.

MAR 8 - 1945 (Date rec'd by local registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6/1945 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/21/1945, to 3/6/1945 and that I last saw h. alive on 3/6/1945

Immediate cause of death Cardio-respiratory failure

Due to a. Emphysema

Due to senility not determined

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: Emphysema

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. I. M. Greenberg, M.D.
Address Grant Hospital Date signed 3/7/45

626664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47C

626664 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Un
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 541 Haw Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Liner Kelley.

3 (b) If veteran, name war

3 (c) Social Security account No.

4. Sex F. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jessie Kelley.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1889

8. AGE: Years 56 | Months 1 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jeffers Wheatley
13. Birthplace Cambridge Md.

MOTHER
14. Maiden Name Celia Wheatley
15. Birthplace St. Marys Co.

16 (a) Informant John A. Kelley
(b) Address 641 Haw. Street

17 (a) ..... (b) Date thereof 3 11 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.
W.B. SPRING S

18 (a) Funeral director Walter A. Bentz
(b) Address 39 W. Hamburg St. Balto. Md.

19 (a) Mar 8 - 1945 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6/ 1945, at 5:1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1945 to 3/6 1945 and that I last saw h[illegible] alive on 3/6 1945.

Immediate cause of death Respiratory Failure — Duration: 1 hr.?

Due to Pleural effusion — Duration: 1 mo.?

Due to Bronchogenic Carcinoma Poss. Pulm. of Isc. — Duration: Year?

Other Conditions CVA's Lues, Hypertensive Ht. Disease
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Cancer of lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Perry Futterman M. D.
Address University Hospital Date signed 3/7/45.

X

G26665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. G26665

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 631 S. Charles St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 631 S. Charles St
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country China

3 (a) FULL NAME Tom Sing

3 (b) If veteran, name war	3 (c). Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	yellow	married

6 (b) Name of husband or wife via China - do not know name
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April ? 1875

8. AGE: Years	Months	Days	If less than one day
69	- ? 11	?	hr. min.

9. Birthplace China
(Town, county, and state)
10. Usual Occupation Carpenter of Restaurant
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Tom Yow
(b) Address 631 S. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn

18 (a) Funeral director Edward Mayo & Co.
(b) Address 108 W North Ave.

19 (Date rec'd by registrar) MAR 8 - 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7- 1945, at about 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2- 1945, to 3-7- 1945, and that I last saw him alive on 3-5- 1945.

Immediate cause of death	Duration
Dilatation of Heart	unknown
Due to	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chester Rieland, M. D.
Address 2532 Edmondson Ave. Date signed 3-7-45

VS 150

G26666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G26666 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution:
Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17day
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 N Glover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FERRIS, MR. MARTIN Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife Mrs. Amelia Ferris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30, 1871

8. AGE: Years	Months	Days	If less than one day
73 74	5	5	hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)
10. Usual Occupation Retired official warden
11. Industry or business

FATHER
12. Name FERRIS, Thomas
13. Birthplace Ireland

MOTHER
14. Maiden Name KENNEY ANNA
15. Birthplace NEW YORK

16 (a) Informant Church Home H.R.
(b) Address Broadway & Fayette

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John J. Morgan
(b) Address 3000 E. Balto. St.

19 (a) [illegible] 1945 by Hattie Worthington Williams
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5 1945, at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1945, to 3-5 1945; and that I last saw him alive on 3-5 1945

Immediate cause of death	Duration
Bronchopneumonia	3 days
Due to Sarcoma of Colon	6 mos.
Due to Terminal Bronchopneumonia	3 days
Other Conditions Generalized arteriosclerosis (Include pregnancy within 3 months of death)	
Date of operation 2-17-45	
Major findings of operation:	
of autopsy: as stated above	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel H. Norwood M. D.
Address Church Home & Hospital Date signed 3-6-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G6667

CWK 90874

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

Registered No. G6667

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 5
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S. Sharp Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daniel Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23-1889

8. AGE: Years 55 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Jones
13. Birthplace Wales

MOTHER
14. Maiden Name Mary Jones
15. Birthplace Wales

16 (a) Informant Records, Balto. City Hospitals.
(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/8/45 (month) (day) (year)
(c) Cemetery or crematory Greenwood
Location Zanesville, Ohio

18 (a) Funeral director J. Wm. Tickner & Sons,
(b) Address Baltimore, Md.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MAR 8 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1945, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-28 1944 to 3-3 1945, and that I last saw him alive on 3-3 1945.

	Duration
Immediate cause of death: Pulmonary tuberculosis bilateral	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred O Dillon M. D.
Address Balto City Hosp. Date signed 3/8/45

G26668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 15-9

G26660 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution? St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 N. Milton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Barczak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (d) Single, ~~married, widowed,~~ or ~~divorced~~

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/7/45

8. AGE: Years | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Bernard Barczak
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Leona Grzyrek
15. Birthplace Wilmington Del.

16 (a) Informant Bernard Barczak
(b) Address 19 N. Milton Ave

17 (a) Burial (b) Date thereof 3/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Jensen Hill Road

18 (a) Funeral director Jos. Rubenstein & Son
(b) Address 1808 Eastern Ave

19 (a) (b) Thos. Williams, Registrar
(Date rec'd by registrar)

MAR 8 1945

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1945, at 10 AM

21. I certify that death occurred on the date above stated, that I attended deceased from March 4 1945 to March 7 1945 and that I last saw her alive on March 7 1945.

Immediate cause of death Asphyxiation - Anemia

Due to

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frederick W. Courtney
Address St Joseph's Hospital signed 3-7-45

G26669 G26669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5102 Belleville Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 84 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5102 Belleville Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Joseph Hosfroo

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 1860

8. AGE: Years 84 | Months 9 | Days 26 29 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Paper Hanger

FATHER
12. Name Louis A. Hosfroo
13. Birthplace France

MOTHER
14. Maiden Name Sarah Ellen O'Farrell
15. Birthplace Baltimore Md

16 (a) Informant Alice R Hosfroo
(b) Address 5102 Belleville Ave

17 (a) Burial (b) Date thereof Mar 12 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Harry A. Annarock
(b) Address 4204 Ridgewood Ave

19 (a) MAR 9 1945 (Date Rec'd by Registrar) By (Registrar)

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 8 1945, at 5:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1945 to Mar. 8 1945 and that I last saw h~~e~~is alive on Mar 7 1945

Immediate cause of death	Duration
Chr. Myocarditis	1940
Due to	
Due to Chr. Pancolymphangitis	1940
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Braun

Address 16630 York Rd. Date signed 3/6/45 M. D.

VS 180

G26670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 56B

G26670 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be answered. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 14

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 Booker Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ethel Baker Warren

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	married

6 (b) Name of husband or wife Jefferson Warren
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1905

8. AGE: Years	Months	Days	If less than one day
39	9	29	hr. min.

9. Birthplace Middlesex Co; Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Baker
13. Birthplace Middlesex Co; Va.

MOTHER
14. Maiden Name Jane Robinson
15. Birthplace Middlesex Co; Va.

16 (a) Informant Jefferson Warren
(b) Address 1628 Booker Court

17 (a) Burial (b) Date thereof March 9/45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A A County Md.

18 (a) Funeral director Mrs. Robert A. Elliott
(b) Address 1129 N. Caroline St.

19 (a) (Date received by Registrar) MAR 8 1945 (b) Registrar Hunter-Tyson-Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1945, at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20 1945, to March 5 1945, and that I last saw h[illegible] alive on 3/5/ 1945.

	Duration
Immediate cause of death: Cerebral Embolism	1 hr
Due to: Post Operative Laparotomy	12 days
Due to: Fibromyoma Uteri	-
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation Feb. 22, 1945
Major findings of operation: Fibromyoma Uteri
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Baltimore Virginia M. D.
Address 2243 Madison Ave Date signed 3/7/45

G26671 BALTIMORE CITY HEALTH DEPARTMENT G26671

CERTIFICATE OF DEATH 8 | a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Ann Dunn

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age 19 Years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1945

8. AGE: Years	Months	Days	If less than one day
4	3	8	hr. min.

9. Birthplace Dechester Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph Dunn
13. Birthplace Petersburg W. Va

MOTHER
14. Maiden Name Alice Louise Ridgely
15. Birthplace Dechester Md.

16 (a) Informant Joseph Dunn
(b) Address Ellicott City, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 10, 1945 (month) (day) (year)
(c) Cemetery or crematory St. Johns Cem.
Location Ellicott City, Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.

19 (a) MAR 8 - 1945 (Date rec'd by Registrar) (b) Courtenay Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8th 1945, at 9 A. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Purulent Meningitis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed March 8, 1945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

64 G26672 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Months
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME James Deese

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male
5. Color or race Colored
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12-17-1943
8. AGE: Years 1 | Months 1 mo 2 | Days 17 | If less than one day .....hr. .....min.
9. Birthplace.....
(Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name James Deese
13. Birthplace N. C.

MOTHER
14. Maiden Name Ella Covington
15. Birthplace N. C.

16 (a) Informant 1119 E. Lombard St.
(b) Address Ella Mae Deese

17 (a) Burial (b) Date thereof 3-8-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location Monrol, N. C.
18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brookfield Ave
8-1945
19 (a)..... (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-4- 1945, at 11:20 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Status Thymicus Lymphaticus
.....
Due to.....
.....
Other Conditions.....
.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury.....

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 3-5-45

VS 151

X

the causes of death clearly and legibly.

G26673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

G26673 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write carefully. Your co-operation is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2432 S. Paca St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Meyers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1926

8. AGE: Years	Months	Days	If less than one day
18	11	20	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business For U S Govern

FATHER
12. Name Rubin Oaks
13. Birthplace Va

MOTHER
14. Maiden Name Beatrice Meyers
15. Birthplace Va

16 (a) Informant Beatrice Watson
(b) Address 2432 Paca Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City

18 (a) Funeral director Joseph A Greby
(b) Address 4699 Mount Street
(c) Huntington Williams

MAR 8 - 1945 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1945, at 2:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑ undetermined ☐ and that the causes of death were:

IMMEDIATE CUSE OF DEATH Stab Wound of Neck

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 3rd 1945 1:45 A.M.
(b) Where did injury occur? 2318 Annapolis Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Restaurant While at work? No
(d) Means of injury Stabbed during altercation

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 3rd 1945

VS 151

626674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

626674 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1656 E 25th
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 5
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1656 E 25th
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm E Angenine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Eleanor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20 1874

8. AGE: Years 70 | Months 4 | Days 16 | If less than one day 19 hr. min.

9. Birthplace Frederick Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wm E Angenine
13. Birthplace Md

MOTHER 14. Maiden Name Rebecca Hammel
15. Birthplace Md

16 (a) Informant Mrs John Deary
(b) Address 1656 E 25th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/45 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Frederick Md

18 (a) Funeral director M L Eichelberger & Son
(b) Address Frederick Md

19 (a) (Date received by registrar) MAR 9 1945 (b) Hunting for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 8 19 , at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1944 to 3/6 1945, and that I last saw h alive on 3/6 1945

Immediate cause of death Ch Myocarditis

Due to Ch arteriosclerosis

Due to Ch Diabetes

Other Conditions Ch Nephritis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Tomasten M.D.
Address 133 August St Date signed 3/8/45

G26675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G26675 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring
(c) Hospital or institution: Aged Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 Belvedere & Greenspring (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 60 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Mrs. Max Blackman
(b) Address 2527 Loyola Southway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-45 (month) (day) (year)
(c) Cemetery or crematory Baehr
Location Pikesville Rd & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore

19 (a) MAR 9 - 1945 Registered by number

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1945, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-11 1938 to 3-7 1945, and that I last saw her alive on 3-7 1945.

Immediate cause of death: Hypertensive card. vas. disease
Generalized arteriosclerosis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edgar L Levin

Address Leonardtown Date signed 3/7/45

Reviewed by Huntington Williams, M.D.

X

G66676

BALTIMORE CITY HEALTH DEPARTMENT ✓ G66679 Registered No.

CERTIFICATE OF DEATH 46 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: LEVINDALE HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Whitelock St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY WASSERMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced.~~
M	W	Married

6 (b) Name of husband or wife ESTHER
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Ret
11. Industry or business

FATHER
12. Name Joseph Wasserman
13. Birthplace Russia

MOTHER
14. Maiden Name Nettie -
15. Birthplace Russia

16 (a) Informant Mrs. Nettie Keagle
(b) Address 2309 Bryant Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-45 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location

18 (a) Funeral director Edw. Levin Inc
(b) Address 1439 E. Balto St.

19 (a) MAR 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1945, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1944 to 3-7 1945 and that I last saw h[illegible] alive on March 7 1945

Immediate cause of death Carcinoma of stomach — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Levin M.D.
Address Levindale Date signed 3/12/45

X

G6677 Peter ✓ G6677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2563 W. Fairmount Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-2
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2563 W. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Peter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Barbara Peter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1878

8. AGE: Years 66 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Peter
13. Birthplace Germany

MOTHER 14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs. Barbara Peter
(b) Address 2563 W. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave.

19 (a) MAR 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1945, at 7.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1945 to 3/7 1945 and that I last saw him alive on 3/6 1946.

Immediate cause of death	Duration
Uraemia	2 days
Due to Acute Nephritis	1 month
Due to Myocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. Carter M. D.
Address 2145 W Balto Date signed

VS 150

X

626678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 D

626678
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Lombard & Greene Sts
(b) Street address ~~Elk~~ Balto. Maryland
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Elkridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. Meadowridge Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sadie Snell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	married

6 (b) Name of husband or wife Edward Snell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16. 1885

8. AGE: Years	Months	Days	If less than one day
60	1	21	hr. min.

9. Birthplace Elkridge, Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Nicholas Jackson
13. Birthplace Md

MOTHER
14. Maiden Name Katherine Jackson
15. Birthplace Md

16 (a) Informant Edward Snell
(b) Address Elkridge Md

17 (a) Burial (b) Date thereof 3-11-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Stephens
Location Elkridge, Md.
18 (a) Funeral director F.C. Heimbothom
(b) Address Ellicott City Md.
19 (a) (b)
(Signature of local registrar)

MAR 9 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1945, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1945, to March 6 1945, and that I last saw h~~e~~r alive on March 6 1945

Immediate cause of death	Duration
Respiratory Failure	3 hrs
Due to Peripheral vasc. failure	3 hrs
Due to Post. operative - Colostomy	6 hrs.
Other Conditions Ca. of Recto-sigmoid	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Ca. of Colon
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Helen A Thom M. D.
Address University Hosp. Date signed 3/7/45

X

G26679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

15

Registered No. G26679

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard + Greene

(c) Hospital or institution: Univ Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1223 Sheldon Rd

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Roberta White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/12/1934

8. AGE: Years 10 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Robert White

13. Birthplace Balto md

MOTHER

14. Maiden Name Viola Courtney

15. Birthplace Baltimore, md.

16 (a) Informant mother

(b) Address 1223 Sheldon Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location Balto Co

18 (a) Funeral director Williams & Jackson

(b) Address 916 Penna ave

19 (a) (Date rec'd by registrar) (b)

VS 150 MAR 9 - 1945

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1945 at 12.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1945 to Mar 7 1945, and that I last saw h alive on Mar 7 1945

Immediate cause of death	Duration
TB peritonitis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2/3/45

Major findings of operation: TB peritonitis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature H. Kelly M. D.

Address Date signed

X

G26680 ✓ G26680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 34 E. Heath St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest C. Rowe

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12, 1891

8. AGE: Years	Months	Days	If less than one day
53	4	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Supply Sergt.
11. Industry or business Soldier
FATHER 12. Name Charles Rowe
13. Birthplace Md
MOTHER 14. Maiden Name Susie Horton
15. Birthplace Md
16 (a) Informant Family
(b) Address 34 E. Heath St
17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3-10-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frankstown Rd.
18 (a) Funeral director John H. McCurdy
(b) Address 1520 E. Fort Ave.
19 (a) (b) Williams Registrar
(Date received by registrar) MAR 9 - 1945

VS 200

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7 1945, at 6:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-23 1945 to 3-7 1945, and that I last saw h[illegible] alive on 3-7 1945

Immediate cause of death	Duration
(a) Generalized Peritonitis	
Due to (b) Perforated Gastric Ulcer	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles R. Mitchell M. D.
Address 1213 Light Date signed 3-7-45

X

G-26681 2335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G-26681 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 538 W. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Leslie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1907

8. AGE: Years	Months	Days	If less than one day
37	1 2	12	hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Daniel Leslie
13. Birthplace N. C.

MOTHER
14. Maiden Name Julia
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 3-10-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 538 W Biddle St

19 (a) 3-9-1945 Date rec'd by registrar Chauncey Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1945, at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2, 1945 to Mar. 6 1945, and that I last saw h[im] alive on Mar. 6 1945

Immediate cause of death	Duration
Heart failure	5 days
Due to Acute hemorrhagic nephritis	2 weeks
Due to Exacerbation of chronic glomerular nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto. City Hosp. Date signed 3/7/45

X

G-6682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. G-6682

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22
(c) Hospital or institution: South Balto Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 W. York St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace Harlentan Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Margaret Martin
(b) Address 411 S Green St

17 (a) Buried (b) Date thereof 3/12/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto National
Location Balto City

18 (a) Funeral director Isaiah L Brown & Son
(b) Address 104 W Montgomery St

MAR 9 - 1945 [illegible] Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7-45 19 at 7:55 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Live death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, Homicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock

Due to 2nd degree burns

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-2-45 at 7:30 A. M.
(b) Where did injury occur? 111 W. York St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Explosion of oil lamp.

23. Signature Howard J. Williams M.D.
Medical Examiner.
Date signed 3-7-45

VS 151

X

G26683 Lacy Whitten G26683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 535 W Lanvale
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 W Lanvale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lacy Whitten

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/25/93

8. AGE: Years	Months	Days	If less than one day
51 52	8	11	hr. min.

9. Birthplace Portsmouth Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Robert Whitten
13. Birthplace Va

MOTHER 14. Maiden Name Mollie Evans
15. Birthplace Va

16 (a) Informant Susie Whitten
(b) Address 535 W Lanvale St

17 (a) Burial Brunt (Burial, cremation, or removal) (b) Date thereof 3/10/45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Balto City

18 (a) Funeral director Isaiah L Brunt & Son
(b) Address 108 W Montgomery St

19 MAR 9 - 1945 (Date rec'd by registrar) (b) Washington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1945 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3 1945 to 3/6 1945
and that I last saw him alive on 3/6 1945

Immediate cause of death	Duration
Coronary occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Burt Rhett M. D.
Address 734 D St Date signed 3/7/45

G26684

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 195E

G26684
Registered No.

write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Parkville
(c) City or town Baltimore County (If outside city or town limits, write RURAL and give town)
(d) Street No. 8305 Oakleigh Rd (If rural give location)
(e) Citizen of foreign country? OAKLEIGH (Yes or No)
If yes, name country

3 (a) FULL NAME William Edgar Youngman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Irene Youngman

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) July 24 - 1895

8. AGE: Years 49 | Months 8 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Hazelton Pa. (Town, county, and state)

10. Usual Occupation Night Foreman

11. Industry or business

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Mary D. Youngman
(b) Address 8305 Oakleigh Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-45 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) MAR 9 1945 (Date rec'd by local reg.) (b) Huntington Williamsville, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1945, at 6 40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushing Injuries of body and extremities

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-8-45 at 12 40 A.M.
(b) Where did injury occur? 1449 Key Highway
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury Explosion of boiler

23. Signature Robert Lee Sutton M.D.
Medical Examiner
Date signed March 8 1945

X

626685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1643 Ruxton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Jerome T. Caffrey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	maried

6 (b) Name of husband or wife Louise A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/31/1866

8. AGE: Years	Months	Days	If less than one day
78	2	7	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Terrence Caffrey
13. Birthplace unknown

MOTHER
14. Maiden Name Catherine Quinn
15. Birthplace unknown

16 (a) Informant Louise A. Caffrey
(b) Address 1643 Ruxton Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 3/10/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director William C ook, Inc.
(b) Address 1217 St. Paul Street

19 (a) MAR 9 - 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1945 at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to March 8 1945, and that I last saw him alive on March 7 1945.

Immediate cause of death	Duration
Uremia	
Senility	
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: None
(a) Accident, suicide, or homicide Fell down 5 steps at
(b) Date of occurrence Feb 24 at 6:30 P.M.
(c) Where did injury occur? Home - Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury fell down 5 steps.

23. Signature W. E. Weedle
Address 7314 - M Dolfield Date signed 3/8/45

Approved by Howard J. Mead, M.D. X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66686 / 8/a — Registered No. G66686

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Wixon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	married

6 (b) Name of husband or wife James.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-2-1901

8. AGE: Years	Months	Days	If less than one day
43	10		hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Major Broom
13. Birthplace S. C.

MOTHER
14. Maiden Name B. McNeal
15. Birthplace S. C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9, '45 (month) (day) (year)
(c) Cemetery or crematory Shipped to
Location Fayetteville, N. C.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (b) Registrar

MAR 9 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1945 at 12 midnight M

21. I certify that death occurred on the date above stated; that I attended deceased from March 6 1945 to March 6 1945, and that I last saw her alive on March 6 1945.

Immediate cause of death	Duration
Cerebro-spinal meningitis	
Due to Pneumococcus Type 12	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus
Address Johns Hopkins Hosp. Date signed 3/7/45

Kattus · X

VS 150

626657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

626657 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(or) Street No. 600 Patapsco Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Galiras

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Angelo

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years	Months	Days	If less than one day
36			hr. min.

9. Birthplace Greece
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name ama Docos
13. Birthplace Greece.

MOTHER
14. Maiden Name agathagela
15. Birthplace Greece

16 (a) Informant angelo Kalivas
(b) Address 600 Patapsco ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Loraine Creek, Sec

18 (a) Funeral director Lanahan mc.
(b) Address 440 E. North.

19 (a) MAR 9 - 1945 (b) Registrar
(Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5 1945, at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1945, to 3/5 1945, and that I last saw her alive on 3/5 1945

Immediate cause of death	Duration
Peripheral circulatory collapse	
Due to	
Due to	
Other Conditions Cholecystitis & cholelithiasis (Include pregnancy within 3 months of death)	

Date of operation 3-3-45

Major findings of operation: Cholecystitis & cholelithiasis

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard V Stier M. D.
Address St Agnes Hosp. Date signed 3-6-45

VS 150

X

Helen House

6688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56 B

Registered No. G66680

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Dunn St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen House

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Moses House

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3 1917

8. AGE: Years 27 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name L. Cane
13. Birthplace Summerton So Carolina

MOTHER
14. Maiden Name L. A. Butler
15. Birthplace Summerton So Carolina

16 (a) Informant Moses House
(b) Address 415 Dunn St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 12 1945 (month) (day) (year)
(c) Cemetery or crematory Summerton So Carolina
Location Clarendon County

18 (a) Funeral director Joseph A. Lively
(b) Address 408 N Mount Street

19 MAR 9 - 1945 (b) (Date rec'd by Registrar) Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1945 at 7:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-26-45 1945 to 3-7 1945, and that I last saw h alive on March 7 1945.

Immediate cause of death: Pulmonary Embolism — Duration: 3 days

Due to:

Due to: Puerperium and Hysterectomy

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 2-27-45

Major findings of operation: Pelvic abscess

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Washington Williams M.D.

Address 803 N Fremont Ave Date signed 3-8-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 160

G66689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G66689

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given, and the causes of death clearly and legibly. Physicians: please write the cause of death in plain terms; correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 Stamford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 Stamford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM JAMES HAYES

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Helen Force Hayes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1876

8. AGE: Years	Months	Days	If less than one day
68	5	10	hr. min.

9. Birthplace Thompson Ridge, N. J.
(Town, county, and state)
10. Usual Occupation Retired Supt.
11. Industry or business Water Front Construction Co.

FATHER
12. Name John Hayes
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia Bunion
15. Birthplace Ireland

16 (a) Informant Mr. Arthur J. Hayes
(b) Address 605 Stamford Road

17 (a) Removal (b) Date thereof 3/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory East Ridgelawn
Location Delawanna, N. J.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Maryland

MAR 9 - 1945 (b) Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1945, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6, 1944, to March 8, 1945, and that I last saw him alive on March 8, 1945.

Immediate cause of death	Duration
Cardiac Insufficiency	
Due to Myocarditis	
Due to Generalized Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edgar H. Kupp M.D.
Address 3030 Edmondson Ave. Date signed 3/9/45
M. D.

G26630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 Q

Registered No. G26630

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Arlington Ave Walbrook
(rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Hattie Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21st 1877

8. AGE: Years 67 64 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charles Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Lucy Neal
15. Birthplace Md

16 (a) Informant William R. Walker
(b) Address 447 Jefferson Ave Towson Md

17 (a) Buried (b) Date thereof 3-9-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest
Location Towson Balto co. Md.

18 (a) Funeral director Bryant Mamie V. Knight
(b) Address 725 Chapel St

MAR 9 - 1945 (a) (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1945, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/2 1945, to 3/7 1945, and that I last saw h[im] alive on 3/7 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James D. Cain.
Address Provident Hospital Date signed 3/7/45 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. 626691

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. Co.
(c) City or town Towson
(If outside city or town limits, write RURAL and give location)
(d) Street No. 116 Chesapeake Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-8-81

8. AGE: Years 63 64 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Practical Nurse

11. Industry or business

FATHER
12. Name James Fletcher
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Digg
15. Birthplace

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Record

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-1945 (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest
Location Towson Balto Co. Md

18 (a) Funeral director Bafsont Mamo & Ho Knight
(b) Address 724 Aisquith St

19 (c) MAR 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1945 at 9 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to March 7 1945 and that I last saw her alive on Mar 7 1945

Immediate cause of death Overwhelming debilitation and infection

Due to Adenocarcinoma of rectum

Due to multiple fecal fistulae + breakdown of colostomy

Other Conditions "Miles operation"

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: C multiple metastasis? peritonitis

of autopsy: Canc., pyelitis, fistulae

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Engelman MD
Address 1111 Date signed 3-8-45

VS 150

626632 X ✓ 626632

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1310
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 North Broadway
(c) Hospital or institution: Church Home + Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Todd Station (If outside city or town limits write RURAL and give town)
(d) Street No. Fort Howard, Balt. Md (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Emma A. Diven

3 (b) If veteran, name war
3 (c) Social Security Account No. —

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mr. Hugh E. Diven
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18 1887

8. AGE: Years 57 | Months 3 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Ludwig Faber
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Raffetel
15. Birthplace Steinmark

16 (a) Informant Hugh E. Diven
(b) Address N. Howard, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-45 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Rockville, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 9 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7/45 1945, at 2 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/23/45 1945 to 3/7/45 1945 and that I last saw h.. alive on 3/6/45 19..

Immediate cause of death	Duration
Uremia	1 month
Due to: chronic ~~glomerulo~~ nephrosclerosis	yrs
Due to hypertension and arteriosclerosis	yrs
Other Conditions: ~~Hypertension~~ ~~Arteriosclerosis~~	

(Include pregnancy within 3 months of death)

Date of Autopsy
Major findings of operation or autopsy: (?) cerebral Thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marvin H. Davis M.D.
Address Church Home Date signed 3-7-45

X

626633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 5 FB

626633 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1029 W. Lanvale st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 W. Lanvale st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Jones

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	Col	Married

6 (b) Name of husband or wife Elsie
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8-12-1878.

8. AGE: Years	Months	Days	If less than one day
66	6	23	hr. min.

9. Birthplace Virginia (Town, county and state)
10. Usual Occupation Janitor
11. Industry or business W. C. A. O. Broadcasting Co

FATHER
12. Name Louis Jones
13. Birthplace Va.

MOTHER
14. Maiden Name Ellen ?
15. Birthplace Va

16 (a) Informant Elsie Redmond Jones
(b) Address 1029 W. Lanvale st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 918 Penna Ave

19 (a) (Date received by Registrar) MAR 9 1945 (b) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1945, at 12:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 19 , to Mar 8 1945, and that I last saw him alive on Mar 7, 1945

Immediate cause of death Carcinoma of Prostate — Duration 3 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jas D Julian Jr. M. D.
Address 511 N. Sabondee Ave Date signed

G26694 ✓ G26694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 215 N. Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Louise Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female | 5 Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Albert Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1895

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace A. A. Co Md. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Arthur Green

13. Birthplace A. A. Co Md

MOTHER 14. Maiden Name Rachel Thyzman

15. Birthplace A. A. Co Md

16 (a) Informant Albert Smith

(b) Address 215 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 9, '45 (month) (day) (year)

(c) Cemetery or crematory Bethlehem Memorial Park

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder St.

19 Mar 1945 (Date received by registrar) Huntington Williams M.D. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1945 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1/1945 to 3/5/1945 and that I last saw h[illegible] alive on 3/4/1945.

	Duration
Immediate cause of death: Cerebral Apoplexy	4 hrs
Due to: Chronic Valvulitis & Myocarditis	—
Due to: Hypertension	—
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature W. G. Howell M.D.

Address 601 N. Carrollton Ave Date signed 3/7/45

VS 150

G26695 ✓ BALTIMORE CITY HEALTH DEPARTMENT G26695
CERTIFICATE OF DEATH 92D Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 333 E. 21st St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 333 E 21st St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael L. Tighe
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1872
8. AGE: Years 73 | Months - | Days - | If less than one day hr. min.
9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation
11. Industry or business Baltimore Gen Office

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Agnes K. Tighe
(b) Address 333 E. 21st St

17 (a) Burial (b) Date thereof 3-10-1945 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Mary M. Wiedefeld
(b) Address 501 E. 22nd St.

19 (a) Huntington Williams, M.D. Registrar
(Date received by registrar)
MAR 9 - 1945
VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 7 1945, at 11:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1939 to Mar 7 1945, and that I last saw him alive on Mar 7 1945.

Immediate cause of death	Duration
Ca Endo-Myocarditis	6 yrs
Due to Arteriosclerosis & Hypertension	6 yrs
Due to Chr. Hypertrophic Prostatis	3 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William L. Straughn M. D.
Address 10 E Read Date signed 3/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626696

BALTIMORE CITY HEALTH DEPARTMENT ✓ 626696 Registered No.

CERTIFICATE OF DEATH 1147

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1618 Caswell St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 T
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Caswell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie H. Drem

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Walter L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28-1910

8. AGE: Years 34 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Charles Knapp
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary E. Haskell
15. Birthplace Balto.

16 (a) Informant Miss Lillian Knapp
(b) Address 1618 Caswell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-45 (month) (day) (year)
(c) Cemetery or crematory Morland
Location Baltimore

18 (a) Funeral director Leonard J. Rusk
(b) Address 5305 Harford Rd

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MAR 9 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to March 9 1945 and that I last saw h[illegible] alive on March 8 1945.

Immediate cause of death Septicemia — Duration 1 mo

Due to old multiple lung abscess - pyogenic in origin not T.B. — Duration 2 years.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/1/45

Major findings of operation: Hernia + stomach rectal abscess.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elliott K. Mortimer Jr M. D.
Address 2206 St Paul St Date signed 3/9/45

JL G266807 ✓ G266807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4040 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 120 W. 23rd. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roland Edwin Fields

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1920

8. AGE: Years	Months	Days	If less than one day
24	10	9	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles
13. Birthplace Va.

MOTHER
14. Maiden Name Georgia Bright
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location R. I. Co

18 (a) Funeral director Rayner Sanders
(b) Address 412 E. Preston St

19 (a) MAR 9 - 1945 (Date filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1945, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 28 1945, to March 7 1945, and that I last saw him alive on March 7, 1945

Immediate cause of death: Pulmonary tuberculosis bilateral — Duration 9 mo

Due to

Due to

Other Conditions Tbc of pharynx

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Lilton

Address Bal. City Hosp Date signed M D 3/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26698 ✓ G26698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2824 St. Paul Street
(c) Hospital or institution:

12-16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2824 St. Paul Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lawrence B. Foster

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Laura J. Foster

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1- 1864

8. AGE: Years 80 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (town, county, and state)

10. Usual Occupation Supt. of Industry - Federal Penitentiary

11. Industry or business Atlanta, Ga - Retired 4½ years

FATHER
12. Name Solomon D. Foster
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary A. Stevens
15. Birthplace Maryland

16 (a) Informant Mr. Herbert M. Foster
(b) Address 2824 St. Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10-1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 631 Falls Road

19 (a) [illegible] (b) [illegible] Registrar

MAR 9 1945 Huntington Hines

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8- 1945, at 2.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1945 to March 8 1945, and that I last saw h[illegible] alive on March 8 1945.

Immediate cause of death	Duration
Cardiac Dilitation	
Due to (b) Cardiovascular Renal Disease	
Due to	
Other Conditions Cardiac Decomp.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. H. Tyrella M.D.
Address 104 W. Madison Date signed March 9, 45

VS 150

0 X

G26699

BALTIMORE CITY HEALTH DEPARTMENT ✓ 50

CERTIFICATE OF DEATH

G26699
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2909 MCELDERRY ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2909 McELDERRY ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA B. HELLMERS

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: JOHN H. HELLMERS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): JUNE 20 1858

8. AGE: Years: 86 | Months: 8 | Days: 17 | If less than one day: hr. min.

9. Birthplace: BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation: HOUSE WIFE
11. Industry or business: AT HOME

FATHER
12. Name ,? RICHTER
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: GERMANY

16 (a) Informant: CHRISTIAN HELLMERS (SON)
(b) Address: 2909 McELDERRY ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 10/45 (month) (day) (year)
(c) Cemetery or crematory: OAK LAWN
Location: EASTERN AVE EXT.

18 (a) Funeral director: Lilly & Zeth Sons
(b) Address: 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) MAR 9 1945 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 7 1945, at 9/50 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from March 7 1945 to March 7, 1945, and that I last saw her alive on March 7, 1945

Immediate cause of death	Duration
MYOCARDITIS	3
ARTERIOSCLEROSIS	1
Due to	
Due to	
Other Conditions Carcinoma left breast (Include pregnancy within 3 months of death)	?

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Louis F. Klumes M. D.
Address 2623 E. Monument Date signed 3/10/45

RT 93D

G26700

BALTIMORE CITY HEALTH DEPARTMENT ✓ G26700

CERTIFICATE OF DEATH 47c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 540 N. Linwood a ✓
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank J. Lidinsky ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Mary Lidinsky

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1880

8. AGE: Years 64 | Months 11 10 | Days 10 12 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Joseph Lidinsky
13. Birthplace Bohemia

MOTHER
14. Maiden Name Barbara Klebotka
15. Birthplace Bohemia

16 (a) Informant Richard Lidinsky
(b) Address 540 N. Linwood a

17 (a) Sinai (b) Date thereof 3-10-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Ogdt Md

18 (a) Funeral director Frank Carroll Son
(b) Address 900 N. Chester St

19 (a) 1945 Huntington Williams, M.D.
(Date filed by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6/1945, at 9 32 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/12/1945, to 3/6/1945, and that I last saw him alive on 3/6/1945

Immediate cause of death: Cardio-Respiratory failure — Duration

Due to: Bronchopneumonia

Due to: Arteriosclerotic Hrt. Disease, Coronary Sclerosis, Myocarditis, Pneumonia & Cystitis

Other Conditions: Bronchogenic carcinoma & cerebral metastases.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley R. Stanley, M.D.

Address Sinai Hospital Date signed 3/9/45

93D

626701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

626701 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospital 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days) one hour
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 West Biddle
(If rural, give location)
Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME George Washington Swann

3 (b) If veteran, name war	3 (c) Social Security Account No.
?	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	colored	Widower

6 (b) Name of husband or wife Jennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1873

8. AGE: Years	Months	Days	If less than one day
72	1	5	hr. min.

9. Birthplace Phenix, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business ?

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Nellie ?
15. Birthplace

16 (a) Informant George A. Swann
(b) Address 211 W. Biddle St.

17 (a) Burial (b) Date thereof 3-10-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Forest Hill Cem.
Location Cockeysville, Md.

18 (a) Funeral director Jno. George H. Hudson
(b) Address 1631 Druid Hill Ave.

MAR 10 1945 (b) Huntington Williams, M.D.
(Registered by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1945, at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH arteriosclerotic cardio-vascular disease

Due to.....

Other Conditions Decubitus ulcers

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury.....

23. Signature John R. Davis, M.D.
Medical Examiner.
Date signed 3/8/45

G26702 G26702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 E Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 60 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Park Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME [illegible] Deford (Clydia Howard)
3 (b) If veteran, name war: no
3 (c) Social Security Account No.: —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife William Deford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5 1854

8. AGE: Years	Months	Days	If less than one day
90	9	3 4	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Frank Key Howard
13. Birthplace Maryland

MOTHER
14. Maiden Name Lydia Morris
15. Birthplace Maryland

16 (a) Informant Mr. Edward Venable
(b) Address 1307 Park Ave. Balto. 17.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry W Jenkins & Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) (Interred) (b) MAR 10 1945 Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-9- 1945 at 12 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-7- 1945 to 3-9 1945 and that I last saw her alive on 3-8- 1945.

Immediate cause of death Cardiac failure — Duration

Due to Cerebral vascular accident

Due to Arteriosclerotic Heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Paul S. Corane M. D.
Address Union Memorial Hospital Date signed 3-9-45

G26703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

G26703 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert st.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 days. Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County B
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. The Warrington Apts. Bldg. 18. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Jesse Bright Riggs

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1870

8. AGE: Years	Months	Days	If less than one day
75	1	6	hr. min.

9. Birthplace Maryland (Balto)
(Town, county, and state)

10. Usual Occupation Insurance

11. Industry or business

FATHER
12. Name Mr Lawrason T. Riggs
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Bright Turpin
15. Birthplace ?

16 (a) Informant Mr Lawrason Riggs.
(b) Address Old Court Road, Brooklandville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 10 1945 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry W. Deckelmann Sons
(b) Address McCulloh & Richard Sts

19 (a) (Date rec'd by registrar) (b) Hunting for Williams, Registrar

VS 150 MAR 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-9- 1945, at 4:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2- 1945 to 3-9- 1945, and that I last saw him alive on 3-9- 1945

Immediate cause of death Carcinomatosis, generalized. — Duration

Due to

Due to

Other Conditions Arteriosclerotic cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul S. Crane M. D.
Address Union Memorial Hospital Date signed 3-9-45

over

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G26704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1147

G26704 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette & Dukeland Sts

(c) Hospital or institution West Balt. Gen Hosp. 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2259 N. Fulton Ave.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME MR. ROBERT-WOOLSEY-BLEAKLEY

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-5781

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mary Jane Bleakley (nee Magee) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21 1886

8. AGE: Years 58 | Months 11 | Days 16 | If less than one day hr. min. 18

9. Birthplace Belfast Ireland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name John Bleakley

13. Birthplace Ireland

MOTHER 14. Maiden Name Rebecca Green

15. Birthplace Ireland.

16 (a) Informant Mrs. Ann Chapman

(b) Address 405 Thackeray Ave - Catonsville Apt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 | 12 | 45 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Balto. Md

18 (a) Funeral director Geo. Wilson & Son

(b) Address 2503 - Edmondson Ave

19 (a) (Date rec'd by registrar) MAR 10 1945 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 1945, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1945 to 3/8 1945, and that I last saw h. l. alive on 3/8 1945.

Immediate cause of death Respiratory Failure.

Due to Chronic pneumonitis with lung abscess - left lung.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Lung abscess. Pneumonia. Left lung.

Duration

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. M. Silverfeld M. D.

Address West Balt Gen Hosp Date signed 3/9/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS 150

G26705 Dr. Parsons - Selma & Lincoln G26705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 Edgewood St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 526 Edgewood St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John Ambrose Fleishell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Virginia Martin Fleishell (Brown) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6th 1848

8. AGE: Years	Months	Days	If less than one day
96	3	3	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation B & O. R.R.
11. Industry or business Mt Claire

FATHER
12. Name Do not Know
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Do not Know
15. Birthplace " " "

16 (a) Informant Mrs. Ida V. Zafft
(b) Address 526 Edgewood St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3 (month) 12 (day) 45 (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director H. Withrow & Son
(b) Address 2503 Edmondson Ave

19 (a) MAR 10 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9th 1945 at 3a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1934 to Mar 9 1945 and that I last saw h— alive on Mar 6 1945

Immediate cause of death	Duration
(a) Chronic Myocarditis	5 yrs.
Due to Arteriosclerosis	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature W. S. Parsons M.D.
Address Hebbville Date signed 3/10/45

VS 150

G46706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 13 B

Registered No. G46706

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2218 E. North Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2218 E. North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILBUR JACOB BROGUNIER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	212-03-7135

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth P. Brogunier
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) July 4, 1880

8. AGE: Years	Months	Days	If less than one day
64	8	4	hr. min.

9. Birthplace Hagerstown, Maryland
(Town, county, and state)
10. Usual Occupation Sign Painter
11. Industry or business Coca Cola Co.

FATHER
12. Name Marriot Alonza Brogunier
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Marie Rettberg
15. Birthplace Hagerstown, Md.

16 (a) Informant Mrs. Elizabeth P. Brogunier
(b) Address 2218 E. North Avenue

17 (a) Burial (b) Date thereof Mar. 10. 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) MAR 10 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION A. M.

20. DATE OF DEATH March 8 1945, at 4.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1944 to March 8 1945, and that I last saw [illegible] alive on March 7 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? none
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury none

23. Signature X. L. Brogier none
Address 5106 Harford Rd. Date signed 3/8/45 D

VS 150

G26707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

Registered No. 19240

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — St. Agnes Hospital
(b) Street address — Gaston & Wilkens Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Balto.
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6729 Railway Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA MUNSKI RULENZ

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:
4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Julius Rulenz
6 (c) If alive, give age: 57 years
7. Birth date of deceased (mo., day, yr.): June 28, 1897
8. AGE: Years 47 | Months 8 | Days 10 | If less than one day ... hr. ... min.
9. Birthplace: Scranton, Pa.
(Town, county, and state)
10. Usual Occupation: Mach. operator
11. Industry or business: Crown Cork & Seal

FATHER
12. Name: Julius Munski
13. Birthplace: Poland

MOTHER
14. Maiden Name: Catherine Wemsick
15. Birthplace: Poland

16 (a) Informant: Mr. Julius Rulenz
(b) Address: 6729 Railway Ave., Dundalk
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-45 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore, Maryland
18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY
19 (a) MAR 10 1945 (Date rec'd by registrar) (b) Washington Wilson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8-1945, at 8 00 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 2-13 1945, to 3-8 1945, and that I last saw HER alive on 3-8 1945.

Immediate cause of death	Duration
Respiratory Failure	
Due to Uremia (Chronic Cond.)	
Due to Chronic Glomerular Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature: Chas. L. Carr Jr.
Address: St. Agnes Hosp. Date signed 3/8/45 M. D.

VS 150

626703

BALTIMORE CITY HEALTH DEPARTMENT

TH. 92434

CERTIFICATE OF DEATH 131a

626703 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 W. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Israel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife Benjamin Israel (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18th 1898

8. AGE: Years	Months	Days	If less than one day
47	1	20	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Duvall
13. Birthplace Maryland

MOTHER
14. Maiden Name Sallie Doughtery
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

~~17~~ (a) Burial (b) Date thereof 3/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore Md.

18 (a) Funeral director Geo. L. Berger Jr
(b) Address 1512 Holline St.

19 (a) (b)
(Date rec'd by registrar)

VS 116 MAR 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8th 1945 19 , at 6;00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 6th, 1945 to Mar 8 1945, and that I last saw h or alive on Mar 8th 19 45

Immediate cause of death Cerebral accident (probably thrombus)

Due to

Due to

Other Conditions Hypertensive cardiovascular disease; old coronary thrombosis, mural thrombus; chr. Glomerular nephritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Pury Jr. M. D.
Address City Hosp Date signed 3-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

G26709 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 908 Preiss St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Preiss St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruff Jennie Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife James Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1912

8. AGE: Years: 32 | Months: 11 | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Wm. Harry Ruff.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Jennie Butler.
15. Birthplace Charles Co., Md.

16 (a) Informant Mrs. Lillian Ruff.
(b) Address 1048 Brantley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10, 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 522 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) MAR 10 1945 Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5 1945 at 1A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1945 to 3/5 1945 and that I last saw h[illegible] alive on 3/-4 1945.

Immediate cause of death Cerebral Embolism — Duration 5 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury
23. Signature B. J. Hatcher M.D.
Address 1725 Preiss St Date signed 3/9/45

626710 M

626710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 497

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1314 Light St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 Light St (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Hannah M Kaiser

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: -----

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15 1875

8. AGE: Years 69 | Months 5 | Days 22 2 3 | If less than one day ... hr. ... min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Milliner

11. Industry or business

FATHER
12. Name Gustav Kaiser
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Siener
15. Birthplace Germany

16 (a) Informant Esther Kiefer
(b) Address 1314 Light St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director John F. Lakenan
(b) Address 1318 Light St

19 MAR 10 1945 (Date rec'd by registrar) (c) Hunting for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8/45 19 , at 1235A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2- 1944 to 3-8- 1945, and that I last saw her alive on 3-7- 1945

Immediate cause of death: Epithelioma of Vulva & lower abdomen — Duration: 2 mos. years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marylook Wills M. D.
Address 1325 S. Charles Date signed 3-8-46

G66711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G66711 Registered No. 121a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 146 S.Highland Ave.
(c) Hospital or institution:
26-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 146 S.Highland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Ada V.Filler

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm.F.Filler Jr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan.20 ,1880

8. AGE: Years	Months	Days	If less than one day
65	1	7 2 0	hr. min.

9. Birthplace Mich. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Julius Maaske
13. Birthplace Germany

MOTHER
14. Maiden Name Martha Samis
15. Birthplace Norman Canada

16 (a) Informant Filler
(b) Address 146 S.Highland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar.12/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) MAR 10 1945 (Date received by Registrar) Registrar

VS 150

Covers Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9th/45 (Mo.), at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1st 1944 to 3/9/ 1945, and that I last saw her alive on 3/9/45 19.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to	
Due to	
Other Conditions Cardio Renal Vascular (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J N Wilson M. D.
Address 617 W. 40 th St Date signed 3/10/45

~~26712~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. 26712

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Fill correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Emily L. Ely

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23 1883

8. AGE: Years 61 | Months 2 | Days 14 | If less than one day hr. min.

9. Birthplace Darlington Md.
(town, county, and state)

10. Usual Occupation Nurse

11. Industry or business Balto. City Health Dept.

FATHER
12. Name Wm. Ely
13. Birthplace Md.

MOTHER
14. Maiden Name Lavina Strickland
15. Birthplace Pa.

16 (a) Informant Sara E. Miller
(b) Address 1731 N. Charles St. Balto. Md.

17 (a) Burial (b) Date thereof Mch 12, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Darlington Cemetery
Location Darlington, Md.

18 (a) Funeral director John C. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 MAR 1 0 1945 (Date rec'd by registrar) — for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9 1945 at 5 03 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-27 1945 to 3-9 1945 and that I last saw her alive on 3/9 1945

Immediate cause of death	Duration
Cardiac failure	
Due to RHD	
Due to	
Other Conditions Auric fibrillation c multiple embolic catastrophe	

(Include pregnancy within 3 months of death)

Date of operation 2-25-45

Major findings of operation: Gangrene of left leg.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. B. Marmentini M. D.

Address Univ Hosp Date signed 3/9/45

VS 150

G26713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G26713 Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 713 W. Barre St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 W. Barre St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philip W. Geidt

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Maud Geidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1866

8. AGE: Years 78 | Months 10 | Days 10 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation Wood Carver

11. Industry or business

FATHER
12. Name Anthony E. Geidt
13. Birthplace Germany

MOTHER
14. Maiden Name Julia A. Pfeiffer
15. Birthplace Germany

16 (a) Informant Miss Emma Geidt
(b) Address 713 W. Barre St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 12, 1945 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Ave.

18 (a) Funeral director Mr. & Mrs. John W. Teufel & Son
(b) Address 801 W. Fayette St.

19 (a) MAR 10 1945 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 9 1945, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-6 1945 to 3-9 1945 and that I last saw h[illegible] alive on 3-9 1945.

	Duration
Immediate cause of death: Acute Cardiac Failure	1 da
Due to: Chronic Confusional Psychosis	5 yr
Due to: Renal Disease	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph G. Paul Carter
Address 619 Washington Blvd signed 3/9/45

VS 150

6714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 186a

Registered No. 6-6714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully recorded. Be sure to correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4310 Hamilton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4310 Hamilton (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Betz
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John F. Betz
6 (c) If alive, give age 75 years
7. Birth date of deceased (mo., day, yr.) Feb. 13-1868
8. AGE: Years 76 | Months 45 | Days 25 | If less than one day ..... hr. ..... min.
9. Birthplace Baltimore - Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Fred J. Betz
13. Birthplace Germany

MOTHER
14. Maiden Name Christina? ?
15. Birthplace Germany

16 (a) Informant Mr. John F. Betz
(b) Address 4310 Hamilton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

MAR 10 1945 (Date rec'd by Registrar)
(b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1945 at 9.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 7 1945, to March 8 1945, and that I last saw h[illegible] alive on March 8 1945.

Immediate cause of death: Chronic Nephritis — Duration
Due to: Senelety
Due to: Arteriosclerosis
Other Conditions: Fractured Rt Hip; 10 wks ago
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence December 1944 M
(c) Where did injury occur? Balto. (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home While at work? No (Specify type of place)
(e) Means of injury Fell off porch at home

23. Signature Walter Wilderson M. D.
Address 300 Fleming Ave Date signed

VS 150

Approved by Howard A. Welsh M.D. 3/10/45

G26715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

Registered No. G26715

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 E. Chase St
(c) Hospital or institution:
St Frances Academy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 E Chase St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Euphemia Elizabeth Lehmicq

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 26, 1930

8. AGE: Years	Months	Days	If less than one day
15	1	9	hr. min.

9. Birthplace Florida (Town, county, and state)

10. Usual Occupation School Girl

11. Industry or business

FATHER
12. Name John Lehmicq
13. Birthplace Long Island Bahamas

MOTHER
14. Maiden Name Julia Smith
15. Birthplace Long Island Bahamas

16 (a) Informant Mother M. Teresa O.S.P.
(b) Address 501 E Chase St.

17 (a) Removal (b) Date thereof March 10 /45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Fort Pierce Florida

18 (a) Funeral director Mr. Obed A. Elliott Daughter
(b) Address 1129 N. Caroline St.

19 (a) Filed by registrar MAR 10 1945 (b) Registered by Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch. 7 - 1945, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch. 4 1945, to Mch. 7 1945, and that I last saw h[illegible] alive on Mch. 6 1945

Immediate cause of death	Duration
Bronchial Asthma	4 days.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rose A. Jolesaint, M.D.
Address 2329 Jones St Date signed Mch. 9 1945

VS 150

G-26716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G-26716

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 126 S. Castle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 45 y 2d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 126 S. Castle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James J. Bennett (Stanley Jarocinski)

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1945 at 9.50 A.M.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1888

8. AGE: Years	Months	Days	If less than one day
56	5 yrs. 4	2	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mrs. Frances Bennett (Jarocinski)
(b) Address 513 S Regester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12/45 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore City

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) MAR 10 1945 (Date received, by registrar) Huntington Williams M.D. Registrar

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed March 8 1945

VS 151

G26717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G26717

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 825 S. Charles St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, M. (If outside city or town limits, write RURAL and give town)
(d) Street No. 825 S. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Henry Breighton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Grace E.

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1871

8. AGE: Years 74 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Robert Breighton
13. Birthplace Unknown

MOTHER
14. Maiden Name Jane ?
15. Birthplace Unknown

16 (a) Informant Mrs Grace E. Breighton
(b) Address 825 S. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/45 (month) (day) (year)
(c) Cemetery or crematory Wye Mills Cem.
Location Wye Mills, Queen Annes Co.

18 (a) Funeral director John J. Kenny Inc. L.F. Hess
(b) Address 718 Light St.

MAR 10 1945 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8th 1945, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to Mar 8 1945 and that I last saw him alive on Mar 8 1945

Immediate cause of death: Cerebral Hemorrhage — Duration 48 hr

Due to Arterio Sclerosis

Due to Goitre

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. H. Maynard M.D.

Address 14 E. Read St Date signed 3.9.45

VS 150

X

G26718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 B

Registered No. G26718

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 Liberty Heights Av
(c) Hospital or institution: * * *
(d) Length of stay in hospital or inst. (yrs., mos., or days) * 1 5-11
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County * *
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 Liberty Heights Av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Clark McKinney

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 477-10-7519

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: June L. McKinney
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Nov 25-1889

8. AGE: Years 55 | Months 3 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Muncie, Ind (Town, county, and state)
10. Usual Occupation Clothing Designer
11. Industry or business Clothing

FATHER
12. Name Turner McKinney
13. Birthplace Indianna

MOTHER
14. Maiden Name Annette Clark
15. Birthplace Indianna

16 (a) Informant June L. McKinney
(b) Address 3300 Liberty Heights Av

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/10/45 (month) (day) (year)
(c) Cemetery or crematory
Location Mantena Illinois

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 118 W. Mt. Royal Ave

19 (a) ____ (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAR 10 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1945, at 12.05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-26 1945, to 3-9 1945, and that I last saw h[illegible] alive on 3-9 1945.

Immediate cause of death: Carcinoma of prostate — Duration: 2 years.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation 2.2.45.
Major findings of operation: Carcinoma of prostate with metastasis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Lurie M.D.
Address 3400 Hilton Rd Date signed 3/9/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G26719 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2100 W. Old Spring Lane
(c) Hospital or institution: Old Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 N Streeper St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W Burns

3 (b) If veteran, name war: —

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, (widowed), or divorced.

6 (b) Name of husband or wife Anna M Burns

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) About 1851

8. AGE: Years 93 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Alex Burns
(b) Address 3 N. Streeper St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cemetery
Location O'Donnell St

18 (a) Funeral director Wendell E Humphreys
(b) Address 1317 N Broadway

19 (a) MAR 11 1945 (b)
(Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 8 1945 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1942 to March 8 1945, and that I last saw him alive on March 6 1945.

Immediate cause of death: Chronic myocarditis — Duration

Due to:

Due to:

Other Conditions senility

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. M. Fitterman M. D.
Address 2324 Eutaw Pl Date signed 3/12/45

X

626720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 1a

Registered No. 626720

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1803 W. Mosher St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 week
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 Sanford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA L. JOYCE

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Harry G. Joyce

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1867

8. AGE: Years 77 | Months 11 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Baker
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Smith
15. Birthplace Unknown

16 (a) Informant Mrs. Fred Brown
(b) Address 108 Sanford Ave., Catonsville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 11 1945 (Date rec'd by registrar) (b) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1945, at 10:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1944 to Mar 9 1945, and that I last saw h er alive on Mar. 8 1945

Immediate cause of death	Duration
Coronary Thrombosis	12 hrs.
Due to Cardio-Vascular-Renal disease	4 yrs.?
Due to Hypertension	4 yr.?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. E. Urban

Address 803 Bird Ave. Date signed 3-9-45

Catonsville, Md.

Geo. E. URBAN, M.D.

VS 150

G66721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G66721

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1021 Poplar Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: LAURA B. SHILOH

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1862

8. AGE: Years	Months	Days	If less than one day
82	11	3	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Eugene Shiloh
13. Birthplace Albany, N. Y.

MOTHER
14. Maiden Name Rebecca Rush
15. Birthplace Unknown

16 (a) Informant Mrs. Goldie M. Shiloh
(b) Address 1021 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) [illegible] (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1945, at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 7 1945 to March 8 1945 and that I last saw her alive on March 8 1945

Immediate cause of death	Duration
Acute Cardiac Dilatation	6 hrs.
Due to Terminal Bronchopneumonia	2 days
Due to Chronic Valvular Heart Disease - Hypertension - Arterio Sclerosis	20 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph N Zierler M. D.

Address 2318 Eutaw Place Date signed 3/10/45

G26722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G26722

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Paynter Ave. & Dukeland St.
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 Moreland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Gore.

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph F. Gore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 23, 1876

8. AGE: Years 68 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Francis Brosnahan
13. Birthplace Wash., D. C.

MOTHER
14. Maiden Name Sarah E. Reineman
15. Birthplace Balto., Md.

16 (a) Informant Mr. Jos. F. Gore
(b) Address 1504 Moreland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1945, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8 1945 to 3/8 1945, and that I last saw h.e.r. alive on 3/8 1945.

Immediate cause of death	Duration
Cerebral Vascular accident	
Due to Hypertensive Cardio vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address West Baltimore General Hos. Date signed 3/9/45
M. D.

G266723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Registered No. G266723

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2537 St. Paul St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2537 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. SPENCER CLARKE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Dora E. Clarke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1867

8. AGE: Years	Months	Days	If less than one day
77	9	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John S. Clarke
13. Birthplace Md.

MOTHER
14. Maiden Name Emily Norville
15. Birthplace Balto., Md.

16 (a) Informant Miss Esther Clarke
(b) Address 2537 St. Paul St.

17 (a) Burial (b) Date thereof 3/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 11 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 9, 1945, at 7:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1944 to Mch. 9 1945 and that I last saw h[illegible] alive on Mch 6 1945

Immediate cause of death	Duration
Carcinoma of Urinary Bladder	15 mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry O. Athey M. D.
Address 2504 St. Paul St. Date signed 3/10/45

VS 150

G26724 ✓ G26724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1304 N. Central Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 N. Central Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Widower

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6, 1858

8. AGE: Years	Months	Days	If less than one day
86	6	2	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Butler
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Hill
15. Birthplace Md

16 (a) Informant Rebecca Butler
(b) Address 1314 N. Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md

18 (a) Funeral director Joseph F. Lock.
(b) Address 1304 N Central Ave

19 (a) MAR 11 1945 (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 8 1945, at 10 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1945 to 3/8 1945, and that I last saw h[illegible] alive on 3/6 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions Hypertension C V Disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Thompkins
Address 6018 Newhall St Date signed 3/8/45

Funeral from Williams, Md

G26725 BALTIMORE CITY HEALTH DEPARTMENT G26725
CERTIFICATE OF DEATH 61 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Maynard Ave & Garrison Blvd
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2618 Springhill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Freedman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dora Dobres
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov, 15, 1889

8. AGE: Years	Months	Days	If less than one day
55	3	24	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation
11. Industry or business Salesman

FATHER
12. Name Morris Freedman
13. Birthplace Poland

MOTHER
14. Maiden Name Sarah Perzner
15. Birthplace Poland

16 (a) Informant Arnold Freedman
(b) Address 2618 Springhill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Sharrei Zion Cemetery
Location Hamilton Ave
18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave
19 (a) MAR 11 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1945, at 6:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 21 1945, to March 9 1945, and that I last saw h/m alive on March 1 1945.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions Diabetis Mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address West Baltimore General Hospital Date signed 3/9/45 M. D.

94a

VS 180

626726 BALTIMORE CITY HEALTH DEPARTMENT 626726 ✓ Registered No.

CERTIFICATE OF DEATH 939

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave 153
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Goldman

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-8630

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Tailor

FATHER
12. Name Simon Goldman
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Mrs Fannie Goldman
(b) Address 3401 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W Baltimore St

19 (a) MAR 11 1945 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9/ 1945, at 1 05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5/1945, to 3/9/1945, and that I last saw him alive on 3/9/1945

Immediate cause of death Cardio - Respiratory failure

Due to Cerebral vascular accident, left, with aphasia & Coma

Due to Hypertension - C-V Dis., Cerebral arteriosclerosis

Other Conditions Chronic alcoholism

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles H. Steinberg, M.D.
Address Sinai Hospital Date signed 3/12/45

626727 626727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5312 Wayne Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5312 Wayne Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lelia Barker Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Walter L. Smith
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) May 28, 1901

8. AGE: Years	Months	Days	If less than one day
45	9	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Clarence Barker
13. Birthplace Virginia

MOTHER
14. Maiden Name Carrie Foes
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Walter L. Smith
(b) Address 5312 Wayne Ave.

17 (a) Burial (b) Date thereof Mar. 12, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Wilkes Lamoreau
(b) Address 4510 Liberty Heights Ave.

19 MAR 11 1945 (b) Thurston Hill Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1945, at 8.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10, 1944 to March 9 1945, and that I last saw her alive on March 9, 1945.

Immediate cause of death Cardiovascular renal disease — Duration: several years.

Due to essential hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas E. Bayer Jr. M. D.
Address 11 E. Chase St. Date signed 3-10-45

X BAYER

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

626728 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3019 Abell Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3019 Abell Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine G. Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Frederick Ames Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17th about 1871

8. AGE: Years about 73 | Months 5 | Days 22 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER
12. Name Patrick Gilchrist
13. Birthplace Scotland

MOTHER
14. Maiden Name Margaret Finnerty
15. Birthplace Ireland

16 (a) Informant Myra Howard
(b) Address 3019 Abell Ave

17 (a) Burial (b) Date thereof 3/13/45
(Burial, cremation, removal) (month) (day) (year)
(c) Cemetery ~~cemetery~~ New Cathedral
Location Balto Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St.

19 (a) 1945 Registered by registrar Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 9th 1945, at 5-37 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945 to Mch 9 1945, and that I last saw h[illegible] alive on Mch 6 1945.

Immediate cause of death Dilated heart — Duration 2 mons

Due to Chronic myocarditis — 15 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry D. McCarty

Address 37 W. Preston St Date signed 3/10/45 M. D.

VS 150

X

626723 ✓ X 626723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N Broadway
(c) Hospital or institution: ctt Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Aberdeen (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 Defence drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Richards, Mr. Edward.

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Lucy Edwards
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 25 1898
8. AGE: Years 46 | Months 5 | Days 18 | If less than one day hr. min.
9. Birthplace Penn (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business

FATHER
12. Name William Richard
13. Birthplace Wales

MOTHER
14. Maiden Name Sarah John
15. Birthplace Wales

16 (a) Informant Lucy Richards
(b) Address Aberdeen Md 3/12/45

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Md

18 (a) Funeral director William Cook Inc
(b) Address 217 St Paul St

19 (a) MAR 11 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7 1945 to 3-9 1945 and that I last saw h in alive on 3-9 1945

	Duration
Immediate cause of death Shock	2 hrs.
Due to Perforated ulcer of D. I. tract	2 wks.
Due to Fecal peritonitis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2-16-45, 3-2-45
Major findings of operation: Gastric ulcer perforation in first operation
of autopsy: Gastric ulcer perforation with walls of stomach

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George W Bardonner M. D.
Address Church Home Hosp Date signed 3-9-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626730 BALTIMORE CITY HEALTH DEPARTMENT 626730
Registered No.

CERTIFICATE OF DEATH 61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carlton St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36da
(e) Length of stay in Baltimore (yrs., mos., or days) 62yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Curtis Bay
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Ceddox St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Birdie Mae Taylor
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife William (deceased)
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6/4/82
8. AGE: Years 62 Months 9 Days 7 If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Helen A. Opalensky (daughter)
(b) Address 1619 Ceddox St. Curtis Bay

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/45 (month) (day) (year)
(c) Cemetery or ~~Crem~~ Cedar Hill
Location Annapolis Blvd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAR 1 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 1945 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1945 to 3/8 1945 and that I last saw h[illegible] alive on 3/8 1945

Immediate cause of death (Duration)
Cardiac decompensation
Diabetes mellitus
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J. Pratt Jr.
Address St. Joseph's Hosp. Date signed 3/8/45

G26731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G26731 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2229 E.Pratt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2229 E.Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence N.Bemis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Patrick Bemis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar.17-1894

8. AGE: Years	Months	Days	If less than one day
50	11	20	..... hr. ..... min.

9. Birthplace Michigan (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Patrick Bemis
(b) Address 2229 E.Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 14-45 (month) (day) (year)
(c) Cemetery or crematory
Location Winchester, Va.

18 (a) Funeral director John A. Miller
(b) Address 2604 Jefferson St.

19 (a) (b) Registered by registrar Huntington Williams, Mayor

11345

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1945, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1944 to March 10 1945, and that I last saw her alive on March 10 1945.

Immediate cause of death: Cardio-Vascular Renal Disease — Duration: a few

Due to Hypertension Valvular Heart Disease ?

Due to

Other Conditions Cardio-Vascular Decompensation — 2 wks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Grace J. Scruggs, M. D.
Address 2005 E. Fayette Date signed 3/11/45

X

G26732 ✓ G26732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4114 Fairview Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4114 Fairview Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Israel Feldman

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-2703

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Furrier

11. Industry or business

FATHER 12. Name unknown
13. Birthplace Russia

MOTHER 14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Al Feldman
(b) Address 3732 Towanda Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3-11-45 (month) (day) (year)
(c) Cemetery or crematory Lloydcroft
Location Levin Bros

18 (a) Funeral director Jack Levin Bros
(b) Address 1439 E. Baltimore St

19 (a) 3-11-1945 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-9-1945, at 10 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1943, to March 9 1945, and that I last saw h. him alive on March 9 1945

Immediate cause of death	Duration
Myocardial infarction	18 months
Due to Arterio-sclerosis	10 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 17 W Eutaw Pl. Date signed 3/9/45

VS 150

X

G26733 BALTIMORE CITY HEALTH DEPARTMENT G26733

CERTIFICATE OF DEATH

106 B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3422 Chessell Ct.
(c) Hospital or institution: South. Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24d.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town St Charles (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John L Carroll (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18-1889

8. AGE: Years 55 | Months 6 | Days 21 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name James Carton

13. Birthplace Va

MOTHER 14. Maiden Name Rebecca Horton

15. Birthplace Va

16 (a) Informant Daughter - Edith Herron

(b) Address 3422 Chessell Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 13-45 (month) (day) (year)

(c) Cemetery or crematory IOOF Cemetery

Location St CHARLES VA.

18 (a) Funeral director Milton Schilling

(b) Address 3914 S Hanover St

19 (a) MAR 14 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Data furnished to the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1945, at 11 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13- 1945 to 3-9- 1945 and that I last saw her alive on 3-9- 1945

Immediate cause of death: Bronchiectasis — Duration: 20 yrs.

Due to:

Due to:

Other Conditions: Small lung abscesses

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Samuel Ehrlich M. D.

Address 1213 Light St. Date signed 3-10-45

G26734 G26734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 W. 29th St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Charles Morse Chalk

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-05-3484

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Viola Chalk

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10/5/80

8. AGE: Years 65 | Months 4 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Fredericksburg, Va
(Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business —

FATHER
12. Name William R. Chalk
13. Birthplace Md.

MOTHER
14. Maiden Name Ophelia Snelling
15. Birthplace Va

16 (a) Informant Albert E. Chalk.
(b) Address 2811 Miles Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 13/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Chapel
Location Balto Co Md.

18 (a) Funeral director Thanhauser & Donovan
(b) Address 2615-17 Chestnut Ave.

MAR 11 1945 (Date rec'd by registrar)

(b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10/1945 at 12:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9/1945 to 3/10/1945 and that I last saw h/m alive on 3/10/1945.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Cirrhosis of liver

Due to Thrombosis of Portal Veins

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Fred Hopkins, Jr. M.D.
Address Union Memorial Hosp. Date signed 3/13/45

VS 150

G26735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G26735 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3640 Clipper Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3640 Clipper Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard S. Watkins.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Annie E. Watkins
6 (c) If alive, give age 71 years
7. Birth date of deceased (mo., day, yr.) March 9 1865
8. AGE: Years 80 | Months | Days | If less than one day ... hr. ... min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business Blacksmith

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Annie E. Watkins.
(b) Address 3640 Clipper Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 12 45 (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Hampden
18 (a) Funeral director Hendrickson & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) MAR 12 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1945, at 10 30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1945 to Mar 9 1945, and that I last saw him alive on Mar 8 1945.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Chr. Myocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward L. Bassman M. D.
Address 4037 Falls Rd. Date signed 3/20/45

Huntington Williams, M.D.

300 G26736 Shannon Drive
Dr Anderson

G26736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5106 Belair Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5106 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY WECK

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-2314

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Anna Weck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13,1886

8. AGE:

Years	Months	Days	If less than one day
58	11	27	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business Southern Photo Eng.Co.

FATHER
12. Name Casper M. Weck
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Treuth
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Harry Weck
(b) Address 5106 Belair Road

17 (a) burial (b) Date thereof Mar.13,1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Loane-Lee Funeral Home
(b) Address 7401 Belair Road

19 (a) Huntington Williams M.D.
(Date rec'd by registrar)

MAR 11 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10th 1945 8:30AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1945 to March 10 1945 and that I last saw him alive on March 10 1945

Immediate cause of death Coronary thrombosis — Duration

Due to Chronic Myocarditis

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 300 Shannon Drive Date signed
Balto-13 md X 3/10/45

G26737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G26737 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3404 Dennlyn Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Dennlyn Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GERTRUDE W. MILES

3 (b) If veteran, name war: none
3 (c) Social Security Account No. --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John W. Miles
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 29, 1881
8. AGE: Years 63 | Months 7 | Days 10 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles W. Waidner
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Sarah J. Frew
15. Birthplace Ohio

16 (a) Informant Mr. John W. Miles
(b) Address 3404 Dennlyn Rd.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAR 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1945, at 1:30 PM
21. I certify that death occurred on the date above stated; that I attended deceased from March 1st 1944 to Mar 9 1945 and that I last saw h[illegible] alive on Mar. 9th 1945

Immediate cause of death: Carcinoma of Breast — Duration: 2 years
Due to ✓
Due to ✓
Other Conditions ✓
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Harry J. Cates M.D.
Address 517 Scott St. Date signed 3/10/45

G26738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G26738 Registered No. 1210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2617 Kirk Ave
(c) Hospital or institution: ****
(d) Length of stay in hospital or inst. (yrs., mos., or days) ****** 9-7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Petere Monath

3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife M MargaretHanson Monath
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 81861

8. AGE: Years	Months	Days	If less than one day
84		1	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Wood Carver
11. Industry or business Wood Working

FATHER
12. Name George M Monath
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Margaret Manath (Wife)
(b) Address 2617 Kirk Aye

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location C Donnel ST Baltimore Md

18 (a) Funeral director J Melville Jenkins
(b) Address 2713 Kirk Ave

19 MAR 1945 (Date rec'd by registrar) Herrington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1945, at 1 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1945, to 3/9 1945, and that I last saw h[illegible] alive on 3/5 1945.

Immediate cause of death myocardial insufficiency — Duration 3 days.
Due to senility
Due to
Other Conditions arterio-sclerosis, chr. nephritis — Duration ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. C Dolihite
Address 447 N. Kenwood Ave Date signed 3/10/45 M.D.

VS 150

G26739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G26739 / 830 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St
(c) Hospital or institution: Crawford Detreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County Cuyahoga
(c) City or town Cleveland (If outside city or town limits, write RURAL and give town)
(d) Street No. 1740-E-47-St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mary Buttimore Bell

3 (b) If veteran, name war No | (c) Social Security Account No. -?-

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John Bell
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 17-1891

8. AGE: Years 54 | Months 0 | Days 21 | If less than one day hr. min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business —

FATHER 12. Name Henry Swartz
13. Birthplace Penna

MOTHER 14. Maiden Name Alice White
15. Birthplace Penna

16 (a) Informant Mrs Erma Palmer (daughter)
(b) Address 1740-E-47-Cleveland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-45 (month) (day) (year)
(c) Cemetery or crematory Harvard Sprs
Location Cleveland-Ohio

18 (a) Funeral director Sliwer & Monroe Co.
(b) Address 108 W North Ave

19 (a) MAR 11 1945 (Entered by registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 1945 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 9, 1945 to March 10, 1945 and that I last saw h[illegible] alive on March 10, 1945

Immediate cause of death Cerebral Hemorrhage — Duration 4 days (?)

Due to Thrombosis of Cerebral Vessels (?)

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alex Greenfield
Address 1821 Euclid Ave. Date signed 3/11/45

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 159

626740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

626740 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4401 Buckinstown Rd
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4401 Buckinstown Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Davidson Shirley

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Jos. W. Shirley
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) August 30-1870

8. AGE: Years 74 | Months 6 | Days 9 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Fred'k H. Davidson
13. Birthplace Balto Md

MOTHER
14. Maiden Name Hannah E. Bride
15. Birthplace Balto Md

16 (a) Informant Mr. Jos. W. Shirley Jr. (son)
(b) Address Buckinstown Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Edward Mowla
(b) Address 1018 W Fayette Ave

19 (a) 1945 (Date rec'd by registrar) (b) Registrar

Huntington Hospital

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9th 1945, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1st 1944, to March 9th 1945; and that I last saw h[er] alive on March 5th 1945.

	Duration
Immediate cause of death: Acute Cardiac Dilatation with Pulmonary Edema	5 days
Due to Hypertension, Arteriosclerosis	6 months
Due to	
Other Conditions do	

(Include pregnancy within 3 months of death)

Date of operation do
Major findings of operation: do
of autopsy: do

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Schaefer M. D.
Address 1305 N. Calvert St Date signed March 9/45

VS 150

X

G26741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 93D

G26741 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 210 S. Collington ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 210 S. Collington ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Germany

3 (a) FULL NAME Sabina Strayer

3 (b) If veteran, name war	3 (c) Social Security Account No.
no.	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William Strayer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1863

8. AGE: Years	Months	Days	If less than one day
81.	2.	9	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name William Robert Ruthert
13. Birthplace Germany

MOTHER
14. Maiden Name Margaretta
15. Birthplace Germany

16 (a) Informant George Pohmel
(b) Address 210 S Allington ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 17 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Mendel Heppel
(b) Address 315 S. Highland ave

19 (a) 1945 (Date filed by registrar) Harrington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1945, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25 1945, to March 6 1945, and that I last saw h alive on March 7 1945.

Immediate cause of death	Duration
Cardiac Asthenia	2 wks
Due to Chr. Myocarditis	?
Coronary Arteriosclerosis	
Due to	
Other Conditions Senile Dementia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac Pohmel
Address 200 E. Ralph Date signed 3/10/45

VS 150

G26742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G26742
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618. 4. Ellwood ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Kupidlowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Leo Kupidlowski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-28-90

8. AGE: Years 54 55 | Months 4 | Days 10 | If less than one day: hr. min.

9. Birthplace 10-28-90 Balto. Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Frank Heil
13. Birthplace Md.

MOTHER
14. Maiden Name Clara Myers
15. Birthplace Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10 1945 (mo.) (day) (year)

(c) Cemetery or crematory Sacred Heart
Location Loppe Road

18 (a) Funeral director Wendel Hyatt
(b) Address 312. S. Highland Ave

19 (a) APR 1 1945 (Date rec'd by registrar) (b) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8- 1945 at 10 20 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 3-4 1945 to 3-8 1945 and that I last saw h[illegible] alive on 3-8-1945

Immediate cause of death Cerebral Vascular accident — Duration 4 days

Due to Hypertensive Cardio-vascular disease — 8 yrs.

Due to

Other Conditions Extra uterine — Completed

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Cenecin

Address J. Hopkins Hospital Date signed 3-8-45 M.D.

X

G26743

G26743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution: Mt Sinai Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 5
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2027 Pressbury Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Dubbe Caplan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Lazer
13. Birthplace Russia

MOTHER
14. Maiden Name Hannah
15. Birthplace Russia

16 (a) Informant Isaac Caplan
(b) Address 120 Jackson Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-45 (month) (day) (year)

(c) Cemetery or crematory Hebrew Herring Run
Location Dowlays Lane

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E. Balto St

(Date received by Registrar) MAR 11 1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1945, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Mar 11 1945 and that I last saw her alive on March 11 1945

Immediate cause of death	Duration
Cardio-Renal	2 yrs
Vascular Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj Samberg

Address 7128 W. North Ave Date signed M. D. 3/11/45

VS 150

G26744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G26744

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 402 Oakford Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 M

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 402 Oakford Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Victoria Gertrude Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Patrick Clark

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/9/1863

8. AGE: Years 81 | Months 11 | Days — | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER 12. Name Andrew Knell

13. Birthplace Germany

MOTHER 14. Maiden Name Josephine Stephenson

15. Birthplace Germany

16 (a) Informant Mrs. R. S. Dupont

(b) Address 402 Oakford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Old Federal Hill

18 (a) Funeral director John D. Lahey Sons

(b) Address 318 Light St.

19 (a) 3/11/1945 (Date received by registrar) (b) Livingston Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1945, at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 18 1943, to Mar. 9 1945, and that I last saw he alive on Mar. 8 1945

	Duration
Immediate cause of death: Cardiac decompensation.	6 Mos.
Due to: Arteriosclerosis, Hypertension.	11 yrs.
Due to:	
Other Conditions: Acute Bronchitis, Bronchopneumonia, Edema (Include pregnancy within 3 months of death)	2 wks.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward Birner. M. D.

Address 2125 Maryland Ave Date signed 3/10/45

626745 626745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wagner Ave & Oakland St.
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 Woodbourne Ave.
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country ------

3 (a) **FULL NAME** ~~Tenby~~ King Jesse Stevens Warran 3d (Jesse Stevens Warran 3d

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife ----------
6 (c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.) 2/25/45

8. AGE: Years	Months	Days	If less than one day
---	---	12	--hr. ---min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Jesse S. Warram Jr.
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Edith Merryman
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. John Merryman
(b) Address 502 Woodbourne Avenue

17 (a) Burial (b) Date thereof 3/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.
18 (a) Funeral director H. W. Meaks and Sons
(b) Address 805 N. Calvert Street

MAR 11 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1945, at 5:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1945, to March 9 1945, and that I last saw h/ alive on March 9 1945.

Immediate cause of death Cerebral hemorrhage

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Reed W. Baldwin
Address West Balt. General Hosp. Date signed 3/9/45

VS 189

G26746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

G26746
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rehwood & Greene Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town ~~Baltimore~~ Hyde
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/8/45

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Newsboy

11. Industry or business

FATHER
12. Name William Clarence Cook
13. Birthplace Glenarm, Md.

MOTHER
14. Maiden Name Ethel Marie Stokes
15. Birthplace Glenarm, Md.

16 (a) Informant Ethel Cook
(b) Address

17 (a) Burial (b) Date thereof Mar. 13-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Longreen, Md.

18 (a) Funeral director Clarence Arthur Cook, Md.
(b) Address

19 (a) Date rec'd by Local Registrar MAR 14 1945 (b) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9/1945, at 11 55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8/1945 to 3/9/1945 and that I last saw h~~e~~R alive on 3/9 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Intracranial hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Dean Pinchal, M. D.
Address University Hosp. Date signed 3/9/45

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

Dr Frey 3 Granby St

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93C

Registered No. G26747

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1812 W Baltimore
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 W Baltimore (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James H Brennan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7 1871

8. AGE: Years	Months	Days	If less than one day
73	7	29	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Glass Blower
11. Industry or business

FATHER
12. Name Thomas F
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Mitchell
15. Birthplace Ireland

16 (a) Informant Miss Catherine Brennan
(b) Address 1812 W Baltimore

17 (a) Burial (b) Date thereof 3-12-45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md

18 (a) Funeral director George A Fahey
(b) Address Fueton & Fayette

19 (a) Huntington Williams, M.D. (Date received by registrar) Registrar

MAR 11 1945 vs 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 8 1945, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1945, to Mar 8 1945, and that I last saw him alive on Mar 8 1945.

Immediate cause of death	Duration
Chronic Myocarditis	1 yr.
Due to Arteriosclerosis	1 yrs
Due to Arthritis Deformans	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E William Frey M. D.
Address 1928 Penna Ave Date signed 3/10/45

G26748
TN. 92477

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G26748 Registered No. 100a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5309 Hamlin Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Veronica Belcher

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Benj. Belcher (D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb .24th 1900

8. AGE: Years	Months	Days	If less than one day
45	0	14	hr. min.

9. Birthplace Mass.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name David McCord (D
13. Birthplace Scotland

MOTHER
14. Maiden Name Sara Haughey
15. Birthplace England

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/45 (month) (day) (year)
(c) Cemetery or crematory Arlington National
Location Arlington, Va.

18 (a) Funeral director C. Vernon Lenhardt
(b) Address 461 Park Heights

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 11 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION P

20. DATE OF DEATH March 8th 1945 at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1945 to March 8 1945 and that I last saw her alive on Mar. 8th 1945

Immediate cause of death Bleeding esophageal varip ?

Duration
?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. A. Perry, Jr. M. D.
Address City Hosp. Date signed 3-7-45

G26749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G26749

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Oxford. (If outside city or town limits, write RURAL and give town)
(d) Street No. Camp Sagmew (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jean Bare.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12 1922.

8. AGE: Years 16 Months 5 Days 029 If less than one day hr. min.

9. Birthplace N. Carolina (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Arthur Bar
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Cardie Darnell.
15. Birthplace N. C.

16 (a) Informant Byron Shepard
(b) Address New London Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 14 1945 (month) (day) (year)
(c) Cemetery or crematory Oxford
Location Oxford Pa.

18 (a) Funeral director E. Tyson.
(b) Address Bainbridge Pa.

19 (a) MAR 12 1945 Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11 1945 at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5 1945 to 3-11 1946.
and that I last saw her alive on 3-11 1946.

Immediate cause of death Heart failure — Duration
Due to Hypertension
Due to Chr. glomerulo nephritis
Other Conditions
(Include pregnancy within 8 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack C. Morgan, M.D. M. D.
Address U. M. H. Date signed 3-11-45

VS 150

G26750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered No. G26750

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Maryland General Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo. 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 228 N. Luzerne Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHRISTINE ELIZABETH THURLOW

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	100

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Herman Thurlow
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1909

8. AGE: Years	Months	Days	If less than one day
35	6	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Frank, Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Barbara Peska
15. Birthplace Baltimore, Md

16 (a) Informant Mr. Herman Thurlow
(b) Address 228 N. Luzerne Avenue

17 (a) Burial (b) Date thereof 3-12-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Md

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

MAR 12 1945 Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9 1945, at 5.55 P.M.

21. I certify that death occurred on the date above stated: that I attended deceased from 1/24/45 19..., to 3/9 1945, and that I last saw her alive on 3/9 19 45.

Immediate cause of death Pulmonary edema

Due to Rheumatic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul H. Herold

Address Md. Gen. Hosp. Date signed 3/9/45
M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G26731

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1717 Homestead Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 Homestead Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FORREST CHARLES VANSANT

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Catherine Corrigan Vansant
6 (c) If alive, give age: 58 years
7. Birth date of deceased (mo., day, yr.): Mar. 26, 1884
8. AGE: Years 60 | Months 11 | Days 14 11 | If less than one day ... hr. ... min.
9. Birthplace: Baltimore, Md (Town, county, and state)
10. Usual Occupation: Machinist, Burt Mach. Co
11. Industry or business: Oliver & Greenmount

FATHER
12. Name: William H. VanSant
13. Birthplace: Trenton, N.J.

MOTHER
14. Maiden Name: Mary E. Smith
15. Birthplace: Trenton, N.J.

16 (a) Informant: Mrs. Catherine VanSant
(b) Address: 1717 Homestead Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-45 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cemetery
Location: Baltimore, Md

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 MAR 12 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1945 at 9.35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945 to March 9 1945 and that I last saw him alive on March 9 1945

Immediate cause of death: Carcinoma Bladder & Rectum — Duration: 2 yrs.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: 1943 & 1944
Major findings of operation: Cancer of Bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Geo. L. Zimmerman M. D.
Address: 9057 Harford Rd Date signed 3/10/45

X 3/10/45

626752 WERNICK ✓ 626752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1-5 70

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #31
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Fleet St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Wernick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/9/45

8. AGE: Years	Months	Days	If less than one day
			hr. 15 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Newsboy
11. Industry or business

FATHER
12. Name Theodore Steven Wernick
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Irene Krzewicka
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Irene Wernick
(b) Address 1605 Fleet St.

17 (a) Burial (b) Date thereof Mch. 12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave.

19 MAR 12 1945 (b)
(Date rec'd by registrar) Harding for Williams, Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9 1945, at 10 35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1945 to 3/9 1945, and that I last saw h e r alive on 3/9, 1945.

Immediate cause of death Respiratory Failure — Duration

Due to Hydrocephalus

Due to Spina Bifida

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Dean Crawford, M. D.
Address Univ. Hosp. Date signed 3/9/45

X

626753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 626753

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) dsa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 438 E. Fort ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maude Mitchell

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Feb 23 1883

8. AGE: Years	Months	Days	If less than one day
69	5	13	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name John Mitchell
13. Birthplace Baltimore

MOTHER
14. Maiden Name Sophia Dietz
15. Birthplace Baltimore

16 (a) Informant Maude Mitchell.
(b) Address 438 E Fort ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 13 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem Catty
Location

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004-8 Orleans St

MAR 12 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1945, at 10:10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/8/45 at 24/3 10 P. M.
(b) Where did injury occur? Light St & Clement
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? yes
(d) Means of injury Fell down on Street

23. Signature Howard J. Mussen M.D.
Medical Examiner.
Date signed 3-9-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. G66754

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 MO.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 634 S. KENWOOD AVE.
(If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME MR. AUGUST KLINGMEYER

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-2504

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife MRS. MARY KLINGMEYER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/27/90

8. AGE: Years	Months	Days	If less than one day
54	5	9 11	hr. min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)
10. Usual Occupation CLERK.
11. Industry or business

FATHER
12. Name Henry Klingmeyer
13. Birthplace Balto

MOTHER
14. Maiden Name Sophia Volk
15. Birthplace Balto

16 (a) Informant Mary Klingmeyer
(b) Address 634 S Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12 (month), (day), (year)
(c) Cemetery or crematory Meadow Ridge
Location Washington Boulevard

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) 3-9-1945 (b) Hurley for Williams (c) Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 1945, at 12 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 1945, to 3/8 1945; and that I last saw him alive on 3/7 1945.

Immediate cause of death	Duration
PULMONARY EDEMA + RESPIRATORY FAILURE	
Due to CARCINOMATOSIS	
Due to CARCINOMA OF RECTUM + SIGMOID.	
Other Conditions TUBERCULOSIS	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry J. Hanka
Address St. Jos. Hosp. Date signed 3/8/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~26755~~ 6755
AB-92893

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
13B

Registered No. 6755

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1228 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lulie Mackabee

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26- 1877

8. AGE: Years 67 | Months 2 | Days 15 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Vincent Trott (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Jane Branzell
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals-Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Solomons
Location Annapolis Md

18 (a) Funeral director Wilson & Son Inc
(b) Address 1214 Ford St

19 (a) MAR 12 1945 (b) Hunting & Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10- 1945, at 3.45PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24- 1945 to 3-10- 1945, and that I last saw h er alive on 3-10- 1945

Immediate cause of death miliary tuberculosis — Duration ?

Due to

Due to

Other Conditions Bilateral lobar pneumonia; cardiac failure
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Perry, Jr. M. D.
Address City Hosp. Date signed 3-11-45

X

G66756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

42 D

Registered No. G66756

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 1/10/45 at 3:00 PM
(e) Length of stay in Baltimore (yrs., mos., or days) Since 1/10/45 at 3:00 PM

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Somerset
(c) City or town Crisfield (If outside city or town limits, write RURAL and give town)
(d) Street No. - (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ARCHIE LOLON WALSTON

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ada Cook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1887

8. AGE: Years 57 | Months 3 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Crisfield, Md. (Town, county, and state)
10. Usual Occupation Mate
11. Industry or business Merchant Marine

FATHER
12. Name Charlie Walston
13. Birthplace Fairmont, Md.

MOTHER
14. Maiden Name Helen Tyler
15. Birthplace Fairmont, Md.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/45 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Crisfield

18 (a) Funeral director Hopkins & H Hurley
(b) Address 306 Main St Crisfield

MAR 12 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH March 9, 1945, at 10:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10, 1945, to Mar. 9, 1945, and that I last saw him alive on Mar. 9, 1945.

Immediate cause of death: Carcinoma of the right lung with multiple metastases — Duration: Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm H Kerrgan M. D.
Address Baltimore, Md. Date signed 3/9/45

VS 150

MS-58192 Wm. H. Kerrgan

46757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 46757

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2916 O' Donnell St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2916 O' Donnell Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Reese

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Olsen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov - 1883

8. AGE: Years	Months	Days	If less than one day
61	4		hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Thomas J. Corns
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margaret Gross
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Carolyn Hummel
(b) Address 811 E. East ave

17 (a) Burial (b) Date thereof 3/12/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1639 N. Broadway

19 (a) MAR 12 1945 (b) Signature for Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 8 - 1945, at 9:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Scirrhus Carcinoma of Breast

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Williams M.D.
Medical Examiner.
Date signed 3-8-45

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66758 G66758

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1945 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1349 Key Highway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1548 Northwick Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sigvald Arthur Haaland

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret Haaland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21-1918

8. AGE: Years	Months	Days	If less than one day
26	2	20	hr. min.

9. Birthplace Norway
(Town, county, and state).
10. Usual Occupation Marine Engineer
11. Industry or business

FATHER
12. Name Christian Haaland
13. Birthplace Norway

MOTHER
14. Maiden Name Olava Bertine Haven
15. Birthplace Norway

16 (a) Informant Mrs. Margaret Haaland
(b) Address 2915 Overland Ave.

17 (a) Burial (b) Date thereof 3-12-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Baltimore

18 (a) Funeral director Leonard J. Rusk
(b) Address 5305 Wayfort Rd.

19 (a) MAR 12 1945 Huntington Williams, M.E.
(Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10- 1945, at Home

21. I certify that I took charge of the remains described above, held an Inspection of Injury thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractures skull.

Due to

Other Conditions Avulsion of brain, multiple fractures. Laceration, abrasion & contusion
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-8-45 at 12.40 A.M.
(b) Where did injury occur? Bethlehem Shipbldg. Refinery Co. 1349 Key Highway
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Explosion of fuel oil tank

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 3-10-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G26759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G26759

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto Md
(b) Street address 4013 Liberty Hgts Ave
(c) Hospital or institution: — 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 months
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore 10
(If outside city or town limits, write RURAL and give town)
(d) Street No 3524 Rolling Rd
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Albert A. Walter

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Sarah E. Walter

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 13 - 1862

8. AGE: Years	Months	Days	If less than one day
82	9 10	28	..... hr. ..... min.

9. Birthplace York Co Pa.
(Town, county, and state)

10. Usual Occupation Cigar Maker

11. Industry or business —

FATHER
12. Name Charles Walter
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Kaufman
15. Birthplace Germany

16 (a) Informant John T Kirk
(b) Address 3524 Rolling Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 13 - 45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Dunbar Ave Extended

18 (a) Funeral director Walter Burke Bradley Jr
(b) Address 1922 N Dunbar Ave

19 (a) ..... (b) .....
(Date received by Registrar) Registrar

MAR 12 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 11 1945, at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 - 20 1944 to 3 - 11 1945 and that I last saw h[illegible] alive on 3 10 1945

Immediate cause of death	Duration
Arteriosclerosis Coronary	10 yr
Due to Coronary Disease	
Due to Stroke	1 yr
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature John T Abbott M. D.
Address 4509 Liberty Heights Ave Date signed 3-12-45

G66760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 15 76

Registered No. G66760

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raynor Ave
(c) Hospital or institution: West Balto Gen Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 W. Fayrale St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Heidecker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5th 1945

8. AGE: Years | Months | Days 6. | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Geo Heidecker
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Hoban
15. Birthplace Baltimore

16 (a) Informant Mrs. Mary Heidecker
(b) Address 2011 W Fayrale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John J Lowry & Son
(b) Address 900-03 Hollins St

19 (a) MAR 12 1945 (b) Filed by registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/11/45 1945 at 5:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5/45 19 to 3/11/45 19, and that I last saw her alive on 3/11/45 19.

Immediate cause of death	Duration
Pulmonary Atelectasis	
Due to Bronch Tracheo esophageal fistula	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Operated on 3/10/45

Major findings of operation: Atresia Esophagus Tracheo esophageal fistula

of autopsy:

PHYSICIAN
Underline the name to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James A. Donahue M. D.
Address West Balto Gen Hospital Date signed 3/11/45

G66761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G66761

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3008 W. Lanvale St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard C. Mason, Sr

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M.

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Late Alice C. Mason

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar 23rd 1863

8. AGE: Years 81 | Months 11 | Days 14 | If less than one day ____ hr. ____ min. 7

9. Birthplace Baltimore Md
(Town, county and state)

10. Usual Occupation Retired

11. Industry or business Insurance

FATHER 12. Name Richard C. Mason

13. Birthplace Baltimore

MOTHER 14. Maiden Name Louisa Claytor

15. Birthplace Baltimore

16 (a) Informant Mrs. Joseph L. Reilly

(b) Address 3008 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 4300 Old Frederick Road

18 (a) Funeral director John J. Cowan & Son

(b) Address 901-03 Hollins St.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D.

MAR 12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9th 1945, at 9.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1st 1944 to March 9 1945; and that I last saw h[illegible] alive on March 9th 1945

Immediate cause of death Uraemia — Duration 48 hrs

Due to Arteriosclerosis — 4 yrs

Due to Chronic nephritis — 4 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. McDermott M. D.

Address 1136 Poplar Grove St. Date signed 3/19/45

VS 150

G26762 BALTIMORE CITY HEALTH DEPARTMENT G26762

CERTIFICATE OF DEATH 1700 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Washington Blvd & Calhoun (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles N. Snyder

3 (b) If veteran, name war	3 (c) Social Security Account No. 218-09-6693

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
62 61			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Engineer Co
11. Industry or business

FATHER — 12. Name	Isaac N. Snyder
FATHER — 13. Birthplace	Ohio
MOTHER — 14. Maiden Name	Hemiller
MOTHER — 15. Birthplace	Pa

16 (a) Informant Rosa Snyder
(b) Address Wash Blvd & Hillsborough

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/45 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location

18 (a) Funeral director Edward Faulkner
(b) Address 2329 Wash Blvd

19 (a) MAR 1 2 1945 (Date first Duly Qualified Practitioner) (b) Practitioner for Williamsburg Md

MEDICAL CERTIFICATION

20. DATE OF DEATH. March 9 - 1945 at 12:01 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Dis death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed skull

Due to

Other Conditions Crushed chest, evisceration of viscera,
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: Balto. Co.
(a) Date of injury 3-8-45 at 11:15 P. M.
(b) Where did injury occur? Washington Blvd & Calhoun
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Pedestrian Struck by bus

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 3-9-45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626763 TN. 89767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 626763

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 5 & 23
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 730 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Willie Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Janie Lou.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21st, 1904

8. AGE: Years	Months	Days	If less than one day
41	1	17	hr. min.

9. Birthplace S. C (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Josael Williams
13. Birthplace S. C

MOTHER
14. Maiden Name Christine Watkins
15. Birthplace S. C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. William
(b) Address 322 N. Schroeder St.

19 (a) MAR 12 1945 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1945 19 at 3:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13-44 19 to Mar. 8th 19 45, and that I last saw him alive on Mar 8th, 19 1945

Immediate cause of death: Pulmonary tuberculosis bilateral — Duration 3 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Hilton M. D.
Address Balto. City Hosp. Date signed 3/8/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66764

66764

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 771 W. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Dorsey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1933

8. AGE: Years	Months	Days	If less than one day
12			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Howard Dorsey.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Annie Brooks
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Annie Dorsey.
(b) Address 771 Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 13, '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Wilkins
(b) Address 322 N. Schroeder St.

19 (a) MAR 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8/45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7 1945 to 3-8 1945, and that I last saw h/her alive on 3-8 19 45.

Immediate cause of death Cardiac failure and anoxemia — Duration
Due to Peritonsular abscess
Due to Tonsilitis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas G. Klein M. D.
Address Univ. Hospital Date signed 3-8-45

G26765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G26765

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 216 N. Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 216 N. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Ball

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married.

6 (b) Name of husband or wife Florence Ball. 55 yrs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7- 1890

8. AGE: Years	Months	Days	If less than one day
55 yrs	2	-	hr. min.

9. Birthplace Northampton Co. - Virginia.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Jeremiah Ball
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Hall
15. Birthplace Virginia

16 (a) Informant Margret Harris (daughter)
(b) Address 522 N. Fricker St.

17 (a) Burial (b) Date thereof Mar. 12, '45.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1945 at 12:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944 to Mar. 7 1945, and that I last saw h.e. alive on Mar 7 1945.

Immediate cause of death	Duration
Cardiac Decompensation	2 mos.
Due to Myocarditis & Pulmonary Edema	
Due to Pneumonia —	10 days
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas. J. Julian Jr.

Address 511 N. Schroeder St. Date signed 3/8/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 6766

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 749 Saratoga St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Diane Graham

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1916

8. AGE: Years	Months	Days	If less than one day
29	—	—	hr. min.

9. Birthplace South Carolina (?)
(Town, county, and state)

10. Usual Occupation Kitchen Helper

11. Industry or business Hospital

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Diane Dingletary
15. Birthplace Geo - South Carolina

16 (a) Informant ~~Self~~ L. M. Green
(b) Address Lake City, S. C.

17 (a) Burial (b) Date thereof Mar 12 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Shipped to Lake City S.C.

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MR 12 1945 (b) Kate R. Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17 1945, to 3/8 1945, and that I last saw her alive on 3/8 1945

	Duration
Immediate cause of death Respiratory failure	2½ min
Due to Toxemia	17 days
Due to Pulmonary Tuberculosis	
Other Conditions Anemia	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Penny Fatherree M. D.
Address University Hospital Date signed 3/9

X

VS 150

626767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940 Registered No. 626767

626767

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 634 N.Denison St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 634 N.Denison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter C.McDowell,

3 (b) If veteran, name war	3 (c) Social Security Account No.
-----	174-09-6277

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mabel H.McDowell.
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) July 4.1895

8. AGE: Years	Months	Days	If less than one day
49	8	7	....hr. ....min.

9. Birthplace Butler Penna.
(Town, county, and state)
10. Usual Occupation Auto Mechanic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Penna,

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Mabel H.McDowell,
(b) Address 634 N.Denison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March13.1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director George W.Little,
(b) Address 2700 Edmondson Ave.

(a) Date received MAR 12 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 11 1945, 19..., at ...M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18-45 19..., to 3-11-45 19..., and that I last saw h... alive on 3-10-45 19...

Immediate cause of death	Duration
Cerebral Embolism	
Due to Coronary Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ...at ...M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry L. Lintel M. D.
Address 2703 Edmondson Date signed 3-12-45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

195E Registered No. 626760

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Md. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 Linden ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Gennaro Desposito

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 56 | Months | Days | If less than one day .....hr. .....min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Pipe Fitter

11. Industry or business Bethelm Fairfield

FATHER
12. Name Michael D'esposito
13. Birthplace Italy

MOTHER
14. Maiden Name Theresa Russo
15. Birthplace Italy

16 (a) Informant Mrs D'Esposito
(b) Address New Jersey N. J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12th 1945 (month) (day) (year)

(c) Cemetery or crematory.....
Location Jersey City N. J.

18 (a) Funeral director Leo G. Cook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) MAR 12 1945 Huntington Williams M.D. Registrar
(Date rec'd by Registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6- 1945; at 7 40 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-4-45 at 11/4 2:30 P.M.
(b) Where did injury occur Bar of Altamont Hotel
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Unknown

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 3-7-45

Causes are especially important. Physicians: please write the causes of death clearly and legibly.

G26769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G26769

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. + Linden Ave.
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Queen Ann Road #16
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur L. Gillem

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 | 1 | 1886

8. AGE: Years	Months	Days	If less than one day
58	11	9	hr. min.

9. Birthplace Jamestown New Jersey
(Town, county and state)
10. Usual Occupation Retired Clerk
11. Industry or business U.S. Post Office

FATHER
12. Name Louis Gillem
13. Birthplace [illegible]

MOTHER
14. Maiden Name Edith O. Gillem
15. Birthplace [illegible]

16 (a) Informant Mrs. B. Gillem
(b) Address Owings Mills Md.

17 (a) Burial (b) Date thereof Mar 13-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Peter Dove
(b) Address 2324 N. Charles St.

19 MAR 12 1945 (b) Registrar's signature Huntington Williams, M.D.

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MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1945 at 6 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3 1945 to 3/10 1945 and that I last saw him alive on 3/10 1945

Immediate cause of death	Duration
Pulmonary Edema	
Pulmonary Infarction	
Due to Auricular Fibrillation	
Due to Arteriosclerotic C.V. Disease	
Other Conditions Terminal Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l Hospital Date signed 3/12/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 62670

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4306 Garrison Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

15 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4306 Garrison Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES W. BALD, SR.

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Elizabeth P. Bald
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1867

8. AGE: Years 78 | Months 2 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business New Balto. Baking Co.

FATHER
12. Name William Bald
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Pauline Klein
15. Birthplace Balto., Md.

16 (a) Informant Mr. Charles W. Bald, Jr.
(b) Address 30 Charlcote Place

17 (a) Burial (b) Date thereof 3/13/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 10 1945 (b) Huntington Williams M.D.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1945, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17, 1944, to Mar. 9, 1945, and that I last saw h im alive on Mar. 9, 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	2 weeks
Due to Hypertensive cardio vascular disease.	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Leidel M. D.
Address 1226 Hanover St. Date signed 3/12/1945.

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 12877

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1624 Mt/ Royal Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 Mt. Royal Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES A. KOUK

3 (b) If veteran, name war: --

3 (c) Social Security Account No. 218-01-6787

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Gertrude M. Kouk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1889

8. AGE: Years	Months	Days	If less than one day
55	4	24	hr. min.

9. Birthplace Hanover, Pa. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Koppers Co. (Bartlett-Hayward Division)

FATHER
12. Name Charles A. Kouk
13. Birthplace Hanover, Pa.

MOTHER
14. Maiden Name Lydia Staley
15. Birthplace Pa.

16 (a) Informant Mrs. Gertrude M. Kouk
(b) Address 1624 Mt. Royal Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1945 to March 11 1945, and that I last saw h alive on 3/9 1945.

Immediate cause of death Coronary Thrombosis — Duration 4 weeks
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. C. Smith
Address 1223 E Monument Date signed 3/12/45 M. D.

VS 150

626772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51C

626772 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 Argyle Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Harrison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-5-01

8. AGE: Years 44 Months 2 Days 6 If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business

FATHER
12. Name Thomas Harrison
13. Birthplace Va

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3-14-45
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Baltimore County Md

18 (a) Funeral director William G Jackson
(b) Address 916 Pennsylvania ave

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1945 at 6:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1945 to Mar 11 1945, and that I last saw him alive on Mar 11 1945.

Immediate cause of death: Respiratory failure — Duration: 4 hrs
Due to: Chronic carcinoma of rt. testis
Due to: metastases to liver and lungs
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Manner
Physician William J. Dixon
Johns Hopkins Hospital Date signed 3/12/46

VS 150

X

G26773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63

Registered No. G26773

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): Since 2/17/45
(e) Length of stay in Baltimore (yrs., mos., or days): 3-4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1707 Fairmont Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) **FULL NAME** JUAN BASOCO

3 (b) If veteran, name war: -

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: -

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 21, 1874

8. AGE: Years: 70 Months: 8 Days: 16 If less than one day: hr. min.

9. Birthplace: ? Spain
(Town, county, and state)

10. Usual Occupation: Drag tender

11. Industry or business: US Eng Corps

FATHER
12. Name: Manuel Basoco
13. Birthplace: Spain

MOTHER
14. Maiden Name: Deloris ?
15. Birthplace: Spain

16 (a) Informant: Records, U.S.Marine Hospital
(b) Address: Baltimore, Md.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3/12/45 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd.

18 (a) Funeral director: W. E. Dipple & Sons
(b) Address: Cookman & Penn Sts.

MAR 12 1945

(b) [illegible] Huntington Williams, M.D.

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH: March 9, 1945, at 1:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17, 1945 to Mar. 9, 1945, and that I last saw him alive on Mar. 9, 1945.

	Duration
Immediate cause of death: Pulmonary edema	Unk.
Due to: Aneurysm of aorta	Unk.
Due to: Syphilis, generalized; Arteriosclerotic heart disease; Arteriosclerosis, general; & Other Conditions: Emphysema senile, Cardiac Syphilis of undiagnosed site; Epithelioma, Squamous cell, skin (Include pregnancy within 3 months of death)	Unk.

Date of operation: 2/21/45-Excision of tumor

Major findings of operation: Ca. of ear

of autopsy: None done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: No
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Benjamin F. Jones

Address: Baltimore, Md. Date signed: 3/9/45

VS 180

USEC-59216 X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

626774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 626774

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 Alameda Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dennis Wayne Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19 - 1944

8. AGE: Years: 1 | Months: | Days: 19 | If less than one day: hr. min.

9. Birthplace: Balto (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Harald E. Schneider
13. Birthplace: Balto.

MOTHER
14. Maiden Name: Dorothy L. Lyon
15. Birthplace: Phila. Pa.

16 (a) Informant: Mother
(b) Address: 2912 Alameda Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/45 (month) (day) (year)
(c) Cemetery or crematory: Mount Olivet Memorial
Location: Taylor Ave.

18 (a) Funeral director: W. E. Ogle & Sons
(b) Address: Huntingdon & Pennsylvania Ave.

19 (a) MAR 13 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1945, at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1945 to 3/10 1945, and that I last saw him alive on 3/10 1945

Immediate cause of death	Duration
Acute Congestive failure	1 day
Due to Congenital Heart disease	1 year
Due to	
Other Conditions Bronchitis - Mongolism Pelvis.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. J. L. Strickel M. D.
Address Bon Secours Hospital Date signed 3/10/45

VS 150

646775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 646775

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 S Carolina St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Richard Mathews

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 77 | Months | Days | If less than one day .....hr. .....min.

9. Birthplace unknown
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Golden Brown
(b) Address 521 S. Carolina St.

17 (a).....(Burial, cremation, or removal) (b) Date thereof 3 13 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto

18 (a) Funeral director Walter B. Brune
(b) Address 139 W. Hamilton St

19 (a) MAR 12 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1945, at 7 30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed Mar 6 1945

VS 151

G66776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G66776

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1500 W. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 W. Lanvale.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Butler (Carter)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, ~~married~~, widowed, or divorced: Divorced

6 (b) Name of husband or wife: ~~Harry~~ Silas Carter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1891

8. AGE: Years 53 | Months 7 | Days 22 | If less than one day: hr. min.

9. Birthplace: Lancaster Co, Va.
(Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business

FATHER
12. Name: Walter Woods
13. Birthplace: Va.

MOTHER
14. Maiden Name: Julia Lee
15. Birthplace: Va.

16 (a) Informant: Julia W. Smith
(b) Address: 1500 W. Lanvale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 13-45 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location: A. A. Co. Md.

18 (a) Funeral director: Saml. H. Chase Son
(b) Address: 638 N. Gilmor St.

19 (a) (Date received by Registrar) (b) Huntington Williams Registrar

MAR 12 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1945, at 1:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/23 1945, to 3/9 1945, and that I last saw her alive on 3/9 1945.

Immediate cause of death: Coronary Occlusion

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: G. H. Banfield, M. D.
Address 844 N. Carey St. Date signed 3/9/45

(over)

G26777

HEALTH DEPARTMENT—CITY OF BALTIMORE

G26777

CERTIFICATE OF DEATH

83a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 N. Gilmor St. Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Lillian Page

If U.S. Veteran specify WAR

(a) Residence: No. 102 N. Gilmor St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Color	

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Howard Page.

6. DATE OF BIRTH (month, day, year) 1897

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Housewife.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country)

FATHER

13. NAME Charles Baynes

14. BIRTHPLACE (city or town) (State or country) Calvert Co. Md

MOTHER

15. MAIDEN NAME Queenie Gross.

16. BIRTHPLACE (city or town) (State or country) Balto. Md.

17. INFORMANT Mrs. Lillian Williams

(Address) 912 W. Fayette St.

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Auburn Date March 12 1945

19. UNDERTAKER Mrs. Katie R. Williams

(Address) 322 N. Schroeder St.

FILED MAR 12 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 3/7/45, 19

22. I HEREBY CERTIFY, That I attended deceased from 2/21, 19 to 3/7/45, 19

I last saw h alive on 3/6/45 Death is said to have occurred on the date stated above, at 11:20 a m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	5 days

Other contributory causes of importance: Arteriosclerosis Heart disease

Was an operation performed? Date of

For what disease or injury?

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Hal Thomsen, M. D.

(Address) Hollins and Fulton

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact abbreviations of OCCUPATION is very important. See instructions on back of certificate.

Write the causes of death clearly and legibly. Physicians: please write correct age if especially important.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

~~6267~~ 1700 C Registered No. 6267

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles J. Hammett

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 28-1880

8. AGE: Years	Months	Days	If less than one day
64 Yrs	11	14	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Bertha A. Hammett
(b) Address 710 Carroll Street

17 (a) Burial (b) Date thereof 3-14-45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director William Cook Jr. & Son
Address 647 St. Paul St. Bell 142

MAR 12 1945

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 19 20, at 3 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 9/3

(a) Date of injury 3-8-45 at 7 A. M.
(b) Where did injury occur? W. Lombard St. 12' W of Long St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Not
(d) Means of injury Pedestrian struck by car

23. Signature Robert L. Gutman M.D.
Medical Examiner.
Date signed March 12 1945

G26779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G26779

Correct the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1710 Guilford Avenue
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 Guilford Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul William Brady

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23-1882

8. AGE: Years	Months	Days	If less than one day
62	11	18	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Retired showman

11. Industry or business

FATHER
12. Name George A. Brady
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Rumsal
15. Birthplace Germany

16 (a) Informant Mrs. Florence Martin
(b) Address 1710 Guilford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street.

19 MAR 12 1945 (Date received by registrar) (b) Thurington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1945, at 11:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: ~~Natural causes~~ [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester J. Lubinski, M.D.
Medical Examiner.
Date signed

Per. Thurington Williams, M.D.

G26780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G26780

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 Rutland ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Banks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-19-1944

8. AGE: Years: 1 | Months: 1 | Days: 20 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER — 12. Name Joseph Banks sr.
13. Birthplace md

MOTHER — 14. Maiden Name Margie Jancil
15. Birthplace md

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

19 MAR 12 1945 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-9-1945 at 4:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9-1945 to 3-9-1945, and that I last saw h[illegible] alive on 3-9-1945.

Immediate cause of death	Duration
? Asthmatic bronchitis	
Due to ? Capillary bronchitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John K. Birmingham M. D.
Address JHH Date signed 3-9

X

G26761

468620.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 471D

Registered No. G26761

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 Banner St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosine Champion

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-21-78

8. AGE: Years	Months	Days	If less than one day
67	1	19	hr. min.

9. Birthplace Ala. (Town, county, and state)

10. Usual Occupation House work.

11. Industry or business

FATHER
12. Name William Johnson
13. Birthplace ? ?

MOTHER
14. Maiden Name Rida. ?
15. Birthplace S. C.

16 (a) Informant Reynds.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brant Lane

19 MAR 12 1945 (Date rec'd by registrar) (c) Huntington Williams Jr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1945 at 1.05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 8 1945 to March 10 1945 and that I last saw h. m alive on March 10 1945

Immediate cause of death [illegible]
(Metastases to liver)

Due to Respiratory failure

Due to Carcinoma of lung - bronchus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ca of lung & liver

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Manner of injury
Signature William J. Dixon
Address Johns Hopkins Hospital Date signed 3/10/45

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6267

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood and Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: P. G.
(c) City or town: Laurel (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME Alfred Cornwall.

3 (b) If veteran, name war: —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife: Elizabeth Cornwall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 12, 1884

8. AGE: Years	Months	Days	If less than one day
60 64	9	—	— hr. — min.

9. Birthplace: Rockville, Md (Town, county, and state)
10. Usual Occupation: Farmer
11. Industry or business: Own Govt Farm

FATHER
12. Name: Wallace Cornwell
13. Birthplace: Va.

MOTHER
14. Maiden Name: Sarah Williams
15. Birthplace: Va.

16 (a) Informant: Wife Elizabeth Cornwall
(b) Address: Laurel, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/45 (month) (day) (year)
(c) Cemetery or crematory: Ivy Hill
Location: Laurel, Md.

18 (a) Funeral director: Wesley H. Gladden
(b) Address: Laurel, Md.

19 (a) MAR 12 1945 (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12 1945, at 6:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-11-45 to 3-12-1945, and that I last saw him alive on 3-12-1945.

Immediate cause of death	Duration
Heart failure	
Due to	
Due to	
Other Conditions: bleeding from wound peritoneum abscess. (Include pregnancy within 3 months of death)	

Date of operation: none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H. M. Browne M. D.
Address: Univ. Hosp. Date signed 3-12-45

VS 150

G26783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. G26783

PLEASE WRITE PLAINLY, with unfading ink. Every question must be answered. Fill in all blanks, or state definitely that the information cannot be obtained. Physicians: please write the causes of death clearly and legibly. Give exact street address or location. Be sure that the statement of length of residence is complete. Be sure that the correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: St Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1706 N Caroline St (If rural give location)

(e) Citizen of foreign country? yes (Yes or No)

If yes, name country USA

3 (a) FULL NAME Margaret Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife George W. Butler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/13/78

8. AGE: Years	Months	Days	If less than one day
66	10	26	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Henry Trautfelter

13. Birthplace Balto Md.

MOTHER 14. Maiden Name Margaret A. Harris

15. Birthplace Balto. Md.

16 (a) Informant Chas J Hospelt

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/45 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem

Location Taylor Ave

18 (a) Funeral director Jos H. Oglesby

(b) Address 2326 Orleans St.

19 (a) (Filed by) (b) Huntington Williams, M.D.

MAR 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9 1945, at 7:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8 1945 to 3/9 1945; and that I last saw h Sh alive on 3/9 1945.

Immediate cause of death Cancer of Rectum

Due to Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Nathan E Church M. D.

Address St Joseph's Hospital Date signed 3/11/45

G26784

JO #88682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G26784

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos. 15 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 808 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Hand

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Emma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1908

8. AGE: Years	Months	Days	If less than one day
36	11	-0-	hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Thomas
13. Birthplace North Carolina

MOTHER
14. Maiden Name ? Saunders
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 3-15-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 MAR 12 1945 (c)
Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1945, at 11:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23, 1944 to Mar. 8, 1945, and that I last saw h 1m alive on Mar. 8, 1945

Immediate cause of death: Pulmonary Tuberculosis bilateral — Duration 6 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Hillon

Address Balto City Hosp Date signed 3/13/45

X

G26785 BALTIMORE CITY HEALTH DEPARTMENT G26785
CERTIFICATE OF DEATH 46G Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 S.ROSE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 S.ROSE ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK F.STEIGERWALD

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife CLARA STEIGERWALD
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT.14 1885

8. AGE: Years	Months	Days	If less than one day
59	4	25 27	hr. min.

9. Birthplace PITTSBURG PENNA.
(Town, county, and state)
10. Usual Occupation MOULDER
11. Industry or business

FATHER
12. Name LEAPOLD STEIGERWALD
13. Birthplace GERMANY

MOTHER
14. Maiden Name GERTRUDE KUKEL
15. Birthplace GERMANY

16 (a) Informant CLARA STEIGERWALD (WIFE)
(b) Address 517 S.ROSE ST.

17 (a) BURIAL (b) Date thereof MAR. 13/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD
18 (a) Funeral director Lilly + Zarba Co
(b) Address 403 [illegible] Walter S. Williams, M.D.
MAR 12 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 10 1945 at 2/30 AM.
21. I certify that death occurred on the date above stated; that I attended deceased from March 7 1945 to March 9 1945 and that I last saw him alive on March 9, 1945.

Immediate cause of death Pneumonic Bronchial Pneumonia — Duration 7 days
Due to Physical exhaustion
Due to
Other Conditions Malignancy stand the Pancreas — Duration several years
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury
23. Signature John J. Singer M. D.
Address 267 Robalen St. Date signed

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G26786 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 146 N.EAST AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 146 N.EAST AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISA BOWEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife JOHN L.BOWEN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN.12 1861

8. AGE: Years	Months	Days	If less than one day
84	1	29	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name UNKNOWN
13. Birthplace BALTO.MD.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace BALTO.MD.

16 (a) Informant MAMIE MANNION(DAUGHTER)
(b) Address 146 N.EAST AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR.15/45 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE.EXT.

18 (a) Funeral director Libly and Zeiler, INC.
(b) Address 403 S.WOLFE ST.

19 (a) 1945 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR.11 1945, at 5 A.M.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 9, 1945, to Mar. 11, 1945, and that I last saw her alive on Mar. 11, 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Arteriosclerosis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Phil Error Antigrams M. D.
Address 2942 E. Fayette St. Date signed 3/12/45

Huntington Williams M.D.

G26787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G26787 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1023 S. BOULDIN ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 S. BOULDIN ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EVA LUBERTINE

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife JOSEPH LUBERTINE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 25 1894

8. AGE: Years	Months	Days	If less than one day
51	1	13	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name JOHN DIETZ
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name ELIZABETH HARTMAN
15. Birthplace BALTO. MD.

16 (a) Informant Anthony Lubertine (Son)
(b) Address 3916 Fait Avenue

17 (a) BURIAL (b) Date thereof MAR. 14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly & Zeltman
(b) Address 403 S. WOLFE ST.

19 (a) (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 10 1945, at 1/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1943, to June 10 1945, and that I last saw h.er alive on June 9 1945

Immediate cause of death	Duration
Arteriosclerotic:	
Hypertensive C.V. Disease	7-11-43
Cerebral Hemorrhage	1-14-44
Due to Cerebral Hemorrhage	3-7-45
Due to	
Other Conditions None.	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. A. Schumacher M. D.
Address 842 S. Eaton Date signed 3-10-45

VS 150

X

G26788

G-18794

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 160a

Registered No. G26788

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St & Cutland Ave
(c) Hospital or institution:
Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 643 W. Baltimore St #23
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Thompson-Stevenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1945

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER
12. Name Frank Thompson
13. Birthplace ?

MOTHER
14. Maiden Name Helen Stevenson
15. Birthplace Cleveland, Ohio

16 (a) Informant Helen Thompson
(b) Address 643 W Baltimore St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Destroyed by fire

18 (a) Funeral director
(b) Address

19 (a) MAR 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1945 at 1:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14 1945 to 2/19 1945, and that I last saw h 1 alive on 2/18 1945.

Immediate cause of death: Intra-cranial Hemorrhage ?

Due to

Due to

Other Conditions: Prematurity
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams M.D.
Address 615 Med Arts Bldg Date signed 3/19/45

VS 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The causes of death clearly and legibly. correct age is especially important. Physicians: please write the

G26789 BALTIMORE CITY HEALTH DEPARTMENT G26789

CERTIFICATE OF DEATH 137a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address - Redwood + Greene St.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2M-9days
(e) Length of stay in Baltimore (yrs., mos., or days) - 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town - Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 Edna Ave Hale thorpe
(If rural give location)
(e) Citizen of foreign country? - No (Yes or No)
If yes, name country

3 (a) FULL NAME - Philip Sheridan Wareheim

3 (b) If veteran, name war - No

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma M Wareheim

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) - June 14 1867

8. AGE: Years 77 78 | Months 6 8 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace - Carroll Co., Md.
(Town, county, and state)

10. Usual Occupation - Produce

11. Industry or business -

FATHER
12. Name - ? Samuel Wareheim
13. Birthplace ? Carroll Co

MOTHER
14. Maiden Name - ? Mary Moreland
15. Birthplace ? Carroll Co

16 (a) Informant - Mrs Hester Disney
(b) Address 1723 Edna Ave Hale thorpe Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 15/45 (month) (day) (year)

(c) Cemetery or crematory Pleasant Valley
Location Carroll Co

18 (a) Funeral director H. Bankard & Son
(b) Address Westminster Md

19 (a) Huntington Williams, M.D. (Date received by registrar) Registrar

MAR 12 1945

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH - 3/12 1945, at 7 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 21 1945 to March 11 1945 and that I last saw him alive on 3/11 1945.

Immediate cause of death - General debility

Due to - Inoperable ulcer

Due to Prostatic hypertrophy + diverticula of bladder

Other Conditions - Pontaneous sepsis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Hoard M. D.
Address University Hosp Balto, Md. Date signed 3/12/45

G26790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G26790

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18d
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3705 Hudson St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Cornelius Sharpness (SCHERPENISSE)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-07-3891

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Marie Sharpness
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) April 9, 1893

8. AGE: Years	Months	Days	If less than one day
51	11	0	____ hr. ____ min.

9. Birthplace Holland (Town, county, and state)
10. Usual Occupation Rigger
11. Industry or business Shipyard

FATHER
12. Name Marinus Sharpness
13. Birthplace Holland

MOTHER
14. Maiden Name Martha Aranesman
15. Birthplace Holland

16 (a) Informant Marie Sharpness (Wife)
(b) Address 3705 Hudson St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-13-45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ PARKWOOD
Location TAYLOR AVE., BALTO. CO.

18 (a) Funeral director Charles S. Zeiler.
(b) Address 3605 FAIT AVE.

19 (a) Filed Mar 9 1945 (b) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1945, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1945, to March 9 1945, and that I last saw h alive on March 9 1945.

Immediate cause of death	Duration
?? miliary tbc. involving liver, spleen, & right lung	6 weeks
Due to	
Due to	
Other Conditions acute hemorrhagic cystitis, ureteritis, & pyelitis	1 week

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: absent

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marion H. Davis M. D.
Address Church Home Date signed 3-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if possible. Write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

VS 186

G26791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 567

Registered No. G26791

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every item correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1013 1/2 Lows St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie Zuskin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-93

8. AGE: Years 51 | Months 2 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Nathan Turk
13. Birthplace Russia

MOTHER
14. Maiden Name Ethel ?
15. Birthplace Russia

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 13 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location German Hill Road

18 (a) Funeral director Sol Levinson & Bro
(b) Address 1124-26 W North ave

19 MAR 13 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1945 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1945 to Mar 12 1945 and that I last saw h[illegible] alive on Mar 12 1945

Immediate cause of death Post — Operative Pneumonia. Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2/24/45

Major findings of operation: Myxadenoma of ovary

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John Chambers
Address Johns Hopkins Hosp. Date signed 3/12/45

VS 150

G26792 BALTIMORE CITY HEALTH DEPARTMENT G46792

CERTIFICATE OF DEATH 83C

Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 811 W Cross St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) N
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 811 W. Cross St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary E Warfield
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-07-1213

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Thomas E Warfield
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 18 1877

8. AGE: Years	Months	Days	If less than one day
67	3	23	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name Enoch Robinson
13. Birthplace Va

MOTHER
14. Maiden Name Elizabeth Smith
15. Birthplace Va

16 (a) Informant Thomas E Warfield
(b) Address 811 W Cross St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Frank H Seitz
(b) Address 814 W. 36 St

19 (a) MAR 2 1945 (Date rec'd by registrar) (b) Interred for Williamsport, Md. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 11 1945 at 10 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22 1945 to Mar. 11 1945, and that I last saw h-er alive on Mar 11 1945.

Immediate cause of death	Duration
Bronchopneumonia	2 weeks
Due to Cerebral Softening. Generalized Arteriosclerosis	5 weeks 5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Hicks M.D.
Address 517 Acord St. Date signed 3/12/45

6793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 6793

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. YMCA Franklin & Cathedral Sts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Hanes Lare

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 2, 1865

8. AGE: Years	Months	Days	If less than one day
80	0	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Edward V. Lare
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Emily L. Hanes
15. Birthplace Balto., Md.

16 (a) Informant Miss Mildred L. Lare (Niece & Executrix)
(b) Address 2807 Edgewood Ave., Richmond, Va.

17 (a) Burial (b) Date thereof 3/13/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 13 1945 (b) Huntington Williams, M.E.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1945; at 10.45 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D.
Medical Examiner.
Date signed 3/11/45

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. 626794

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7 Elmhurst Road
(c) Hospital or institution: 7

(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 82 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 Elmhurst Road
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Clara Theresa O'Neill

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William A. O'Neill
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1862

8. AGE: Years	Months	Days	If less than one day
82	2	26	-- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name John H. Ball
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Catherine Carr
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Mary J. Lyon
(b) Address 4230 Loch Raven Boulevard

17 (a) Burial (b) Date thereof 3/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

MAR 13 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 12 1945, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 5 1945, to Mar. 12 1945, and that I last saw h.. alive on March 5 1945.

Immediate cause of death Heart failure
Chronic Endo and Myocarditis — Duration 2
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. Gibson Porter
Address 4822 Roland Ave. Date signed 3/13/45

626795 ✓ 626795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 W. Lafayette Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 517 W. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Alfred L. West Jr.

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1-30-1923

8. AGE: Years 22 | Months 1 | Days 18 1/2 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business Automobiles

FATHER
12. Name Alfred L. West, Sr.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ethel Crowdy
15. Birthplace Baltimore Md.

16 (a) Informant Ethel West (mother)
(b) Address 517 W Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/45 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Balto. Md.

18 (a) Funeral director Charles F. Cofer
(b) Address 517 N. Caroline Ave

19 (a) ____ (b) ____
(Date rec'd by registrar) / Registrar

MAR 16 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1945 at 10 M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 5 1944 to 3/11 1945, and that I last saw h— alive on 3/11 1945

Immediate cause of death	Duration
Hodgkin's Disease	3 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. [illegible] Walter

Address 1 [illegible] Pathologist Date signed 3/11/45 M.D.

X

626736 ✓ 626736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1300 W. 40th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 W. 40 St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Kehm

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife. Mathias Kehm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22. 1863

8. AGE: Years	Months	Days	If less than one day
81	7	17 20	hr. min.

9. Birthplace Ausbied
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Rena Hallman
(b) Address 1300 W. 40 St

17 (a) Burial (b) Date thereof 3-13-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MAR 18 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1945, at 1:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 1945, to March 11 1945 and that I last saw h.er alive on March 10 1945

Immediate cause of death	Duration
Acute Dilatation Heart	3 hrs
Acute Myocarditis	3 d.
Due to Senile Senility	3 d.
Due to Chr. Interstitial Nephritis	3 d.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature I J a Stevens M. D.
Address 2818 Harford Ave Date signed 3-17-45

X

626797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1172

626797 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1404 Argyle ave (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Arthur Lowey

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Lula Lowey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891, ?

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Sumpter, S C (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Tinker Lowey
13. Birthplace Sumpter

MOTHER
14. Maiden Name Eliza Jane ?
15. Birthplace Sumpter

16 (a) Informant Rosie Lee Pierce
(b) Address 1404 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 16, 1945 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial Park
Location Baltimore County Md

18 (a) Funeral director Joseph A. Lively
(b) Address 4[illegible] Mount Street, Baltimore, Md

19 (a) MAR 13 1945 (Date rec'd by registrar) (b) Huntington for Nathan Lee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1945, at 7:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 1945, to March 12 1945, and that I last saw him alive on March 12 1945.

Immediate cause of death	Duration
(a) Ruptured Duodenal Ulcer	7
Due to (b) Peritonitis	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: Peritonitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Davison M. D.
Address 1209 Eutaw Place Date signed 3/12

H. L. Davison

VS 150

626738 BALTIMORE CITY HEALTH DEPARTMENT 626738
CERTIFICATE OF DEATH 93D
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l Hosp'l
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 9 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1404 Clarkson ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Wm Zeller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28th 1875

8. AGE: Years 70 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None Blind

11. Industry or business

FATHER 12. Name John G. Zeller
13. Birthplace Md

MOTHER 14. Maiden Name Emaline Shechells
15. Birthplace Md

16 (a) Informant Mr Paul Zeller
(b) Address 1404 Clarkson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15th 1945 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Cedar Hill
Location Annapolis Rd

18 (a) Funeral director Leo Gelbach
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (Date received by Registrar) (b) [illegible] Registrar

VS 16?

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1945, at 12 20 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebro vascular Accident
Cardio vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed March 12 1945

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

626739 O Driscoll 626739

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1251 E Lexington (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Odwyer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1894

8. AGE: Years 50 | Months 6 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name George A Rohleder
13. Birthplace Md

MOTHER
14. Maiden Name Mary A Rohleder
15. Birthplace Md

16 (a) Informant George A. Rohleder
(b) Address 1251 E Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 14th 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo S. Cook
(b) Address 1791-93 N. Patterson Park ave

19 (a) MAR 13 1945 (Date rec'd by registrar) (b) Huntington Hollins M.D. Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11-45 19..., at 9 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9 1945, to 3-11 1945, and that I last saw her alive on 3-11 1945.

Immediate cause of death: Hypostatic Congestion - Pneumonia Lobar

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles B. MacDonald M. D.
Address 1213 Light St Date signed 3-11

PLEASE WRITE PLAINLY, with ordinary pen. Do not abbreviate. Give the exact cause of death for all diseases, injuries, and complications which caused death. Do not report symptoms of mode of dying, such as heart failure, asphyxia, anemia, or uremia. Indicate the duration of each. If death was due to external causes, state the accident, suicide, or homicide, and the means of injury. Give full address of residence. If in a hospital or institution, the usual residence of the deceased. Fill in all items. Be sure that the cause of death is clearly and legibly stated. Be sure that the age is correct. Physicians: please write the cause of death clearly and legibly. This information is especially important.

G26800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G26800 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4210 Springwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4210 Springwood Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian M. Bradley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Edward T. Bradley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10th 1888

8. AGE: Years	Months	Days	If less than one day
56	9	1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Louis W. Hanson
13. Birthplace New Jersey

MOTHER
14. Maiden Name Ella Moffett
15. Birthplace New Jersey

16 (a) Informant Edward T. Bradley
(b) Address 4210 Springwood Ave

17 (a) Burial (b) Date thereof 3/14/1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, MD.

18 (a) Funeral director Lenahan Funeral Home
(b) Address 7401 Belair Road

19 (a) MAR 13 1945 Victor Williams, Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11th. 1945, at 1105 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1945, to March 11 1945, and that I last saw her alive on March 10 1945.

Immediate cause of death	Duration
Myocardial Infarction	3 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward T. Bradley M. D.
Address 9818 Harfield Rd Date signed 3/12/45

X

G26801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G26801

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Monument St.
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. Co.
(c) City or town Fullerton
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belair Rd near Nuford Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joyce Bowman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-9-32

8. AGE: Years 12 | Months 3 | Days 2 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Heath Bowman
13. Birthplace Va

MOTHER
14. Maiden Name Florence White
15. Birthplace Md.

16 (a) Informant Records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch. 14th 1945 (month) (day) (year)
(c) Cemetery or crematory Woodland Park
Location Parkville, Maryland

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

19 (a) MAR 19 1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1945 at 6:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1945 Mar 11 1945 and that I last saw her alive on Mar 11 1945

Immediate cause of death	Duration
Septicemia (staph. aureus and B. coli)	6 days
Due to Acute ulcerative colitis with multiple	9-10 wks.
Due to perforations of intestines	4 wks.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2/13/45 - 2/15/45 - 3/3/45

Major findings of operation: Appendectomy, ulceration & tenderness, ileostomy

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ruth White Emmons M. D.
Address Johns Hopkins Hospital Baltimore, Md Date signed 3/14/45

Huntington Williams, Md

G266802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G266802 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4612 Kavon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4612 Kavon Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William T.C. Willinghan

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-9441

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eleanora Willinghan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31st. 1879

8. AGE: Years	Months	Days	If less than one day
65	4	12	hr. min.

9. Birthplace Balto. Co. Maryland (Town, county, and state)
10. Usual Occupation Carpenter Co. Maryland
11. Industry or busines Consolidated Eng. Co.

FATHER
12. Name William Willinghan
13. Birthplace Balto. Co. Maryland

MOTHER
14. Maiden Name Sarah Fowler
15. Birthplace Balto. Co. Maryland

16 (a) Informant Mrs. W.T.C. Willinghan
(b) Address 4612 Kavon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Maryland

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7401 Belair Road

19 (a) MAR 13 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12th. 1945, at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1944 to 3-12 1945 and that I last saw him alive on 3-11 1945

Immediate cause of death Coronary Thrombosis — Duration 3 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. W. Peake M. D.
Address 4508 Hayes Road Date signed 3-12-45

VS 150

G66803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G66803

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 MONS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1836 E. Fairmount
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Owen B. Sliflatte

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: June 16 1944

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/18/[illegible]

8. AGE: Years | Months: 8 | Days: 24 | If less than one day: hr. min.

9. Birthplace Md — Balt.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Owen Sliflatte
13. Birthplace Va.

MOTHER
14. Maiden Name Bernice Sliflatte
15. Birthplace Va.

16 (a) Informant Mother
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 15 45 (month) (day) (year)

(c) Cemetery or crematory Charlottesville Va.
Location Charlottesville Va.

18 (a) Funeral director Silbaugh-Zesler Inc.
(b) Address 403 E. Baltimore St.

19 (a) MAR 13 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12-1945 at 7.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-11- 1945 to 3-12 1945, and that I last saw h[illegible] alive on 3-12 1945.

Immediate cause of death	Duration
Capillary Bronchitis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John K. Bumingham M. D.
Address JHH Date signed 3-13-45

6804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 30

Registered No. 6 6804

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3512 E. Baltimore Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 64yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3512 E. Baltimore Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Goeb

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 29, 1878

8. AGE: Years	Months	Days	If less than one day
66	11 0	12	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Ice man
11. Industry or business Self

FATHER
12. Name Michael Goeb
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Toneas
15. Birthplace Germany

16 (a) Informant Lawrence Goeb(brother
(b) Address 3228 Foster Avenue

17 (a) Buiral (b) Date thereof 3/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd

18 (a) Funeral director Lilly & Zeke
(b) Address 403 S. Wolfe Street

19 (a) Date received by Registrar MAR 15 1945 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 11 1945 at 6P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1945 to Mar 11 1945 and that I last saw h[illegible] alive on Mar 11 1945

Immediate cause of death	Duration
Acute hepatitis	10 days.
Circulatory Failure	3 days.
Due to Severe Respiratory cold	3 wks.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 320 S. Patterson Park Ave. Date signed 3/13/45

X

G26805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G26805
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1727 Ruxton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor (If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 Ruxton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma D. Seabold

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) ~~Single, married,~~ widowed, or divorced Widow

6 (b) Name of husband or wife John D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1872

8. AGE: Years 72 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Emmitsburg Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Rosenstiel
13. Birthplace Md.

MOTHER 14. Maiden Name Delonis Dukehart
15. Birthplace Md.

16 (a) Informant Edward D. Seabold
(b) Address 353 Wabash Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Ripley & Sons
(b) Address 1827 N. North Ave.

19 (a) 3/13/45 (Date rec'd by registrar) (b) Hunsicker for Williamson, M.R.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1945, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1942 to Mar 11 1945, and that I last saw h... alive on Mar 11 19 45.

Immediate cause of death
Cerebral Hemorrhage
Due to Generalized Atherosclerosis
Due to Dietetic Nutrition

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. E. Needle M.D.

Address 731 - 201 North Ave. Date signed 3/13/45 M. D.

X

626806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 626806

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 722 Carroll St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John Kammerer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife. Elizabeth M.

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 28 - 1905

8. AGE: Years 40 | Months 1 | Days 1/14 | If less than one day ..... hr. ..... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business Eugene Pried Co.

FATHER
12. Name Baltzer Kammerer
13. Birthplace Germany

MOTHER
14. Maiden Name Anna —
15. Birthplace Germany

16 (a) Informant Mrs. Elizabeth M. Kammerer
(b) Address 722 Carroll St.

17 (a) Burial (b) Date thereof 3/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location 3900 B. Frederick Road

18 (a) Funeral director John Conaway Son
(b) Address 900-03 Collins Ave.

19 (a) MAR 13 1945 (Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11- 1945, at 5:40 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Cardiac Failure
Arteriosclerotic Cardio-Vascular Disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 3-12-45

X

546807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 546807

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1713 Aliceanna Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 Aliceanna Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JULIANNA CHRZANOWSKI

3 (b) If veteran, name war	3 (c) Social Security Account No.
----	----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/7/83

8. AGE: Years	Months	Days	If less than one day
61	5	4	hr. min.

9. Birthplace Adomyszla, Poland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Chrzanowski
13. Birthplace Adomyszla, Poland

MOTHER
14. Maiden Name Maryanna Kalyta
15. Birthplace Adomyszla, Poland

16 (a) Informant Miss Teresa Chrzanowski
(b) Address 1713 Aliceanna Street

17 (a) Burial (b) Date thereof 3/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski Sons
(b) Address 1808 Eastern Avenue

19 MAR 13 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1945 at 8:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1945 to Mar. 11 1945 and that I last saw her alive on Mar. 11 1945

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	2 DAYS
Due to VASCULAR SCLEROSIS	???
Due to CHRONIC NEPHRITIS	6 YEARS
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: —
of autopsy: NONE PERFORMED

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph F. Drenga M. D.
Address 209 S. Chester St Date signed 3/12/45

G-6808

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

Registered No. G-6808

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St
(c) Hospital or institution: Home for Incurables 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Margaret Moxley Smith

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wm. E. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11 1868

8. AGE: Years 76 | Months 11 | Days 0 | If less than one day ____hr. ____min.

9. Birthplace Massachusetts (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Charles Henry Moxley
13. Birthplace Mass.

MOTHER
14. Maiden Name Lorrise Marie Floyd
15. Birthplace Mass

16 (a) Informant E. Hartman
(b) Address Home for Incurables

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Stewart & Mowell Co
(b) Address 108 W. North Avenue

19 (a) 3 1945 (Date rec'd by Registrar) (b) Huntington Hollins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1945, at 7:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1st 1938 to March 11 1945, and that I last saw h[illegible] alive on March 9 1945.

	Duration
Immediate cause of death: Congestive Heart Failure	6 weeks
Due to: Arteriosclerosis and Hypertensive Cardio-Vasc. Dis.	25 Many years
Due to:	
Other Conditions: Chronic Hypertrophic Arthritis	38 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thomas Conrad Wyl M. D.
Address 11 E. Chase St. Date signed 3/11/1945
Baltimore 2 Md.

VS 2

Please write plainly, with ordinary pen and ink. Be sure to write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write your name plainly.

6809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

Registered No. 66809

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4219 Vermont Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) –
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4219 Vermont Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Rebecca Yinger

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Edw. C. Yinger
6 (c) If alive, give age – years
7. Birth date of deceased (mo., day, yr.) Mar-1-1861
8. AGE: Years 84 | Months 0 | Days 10 | If less than one day ... hr. ... min.
9. Birthplace Frederick, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Peter Pool
13. Birthplace England

MOTHER
14. Maiden Name ? ? Scheutenhelm
15. Birthplace Germany

16 (a) Informant Mrs. Ralph L. Yinger (son)
(b) Address 815 Pontiac Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 15 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave., City

18 (a) Funeral director Stewart & Mowen Co.
(b) Address 108-W-North Avenue

19 MAR 13 1945 Huntington Williams M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 11th 1945, at 10:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1944 to 3-11 1945 and that I last saw h[illegible] alive on 3-10 1945.

Immediate cause of death: Cardio Vascular Renal disease — Duration
Due to
Due to
Other Conditions Senility
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alpha H. Brantha M. D.
Address 4209 Hunt Ave Date signed 3-13-45

VS 150

PRINT WITH PENCIL, WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-6810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G-6810

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2106 E. Pratt St
(c) Hospital or institution: 1-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2106 E. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY NOVISKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John Noviski (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Not Know ?

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Russian (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name D. Denison
13. Birthplace Russian

MOTHER
14. Maiden Name
15. Birthplace Russian

16 (a) Informant Noviski Family
(b) Address 2106 E. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar-14-45 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Stony Run Md. U.A.C.

18 (a) Funeral director John G. Goebliuckas
(b) Address 423 S. Paca St

MAR 13 1945 (Date rec'd by Registrar) (b) Huntingtown Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March-11-1945, at 6 45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch-4-1945, to Mch-10 1945, and that I last saw her alive on Mch-10-1945

	Duration
Immediate cause of death: acute uremia	about 10 yrs
Due to: Chronic nephritis	
Due to: Hypertension a arteriosclerosis	
Other Conditions: diabetes	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herman Deidel M. D.
Address 2404 Eutaw Pl Date signed 3/13/45

131a

626811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

Registered No. 626811

PLEASE WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 E. Lexington
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 E Lexington
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Baxter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem	Negro	married

6 (b) Name of husband or wife William F. Baxter

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Dec 10, 1883

8. AGE: Years	Months	Days	If less than one day
61	3	-	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Wesley Thomas
13. Birthplace Virginia

MOTHER
14. Maiden Name Lydia Sales
15. Birthplace Baltimore Md

16 (a) Informant William F. Baxter
(b) Address 1217 E. Lexington St

17 (a) Burial (b) Date thereof Mar. 15, 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Baltimore County

18 (a) Funeral director Maida Bailey
(b) Address 1421 E. Jefferson st

19 (a) MAR 13 1945
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1945 at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1945 to March 10 1945 and that I last saw h[illegible] alive on March 9 1945

Immediate cause of death: Hypertensive Cardio Vascular Renal Disease ?

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. K. Adams M. D.

Address 1222 N. Carlton Date signed 3-12-45

VS 150

626812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √157B

626812 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1054 W. Baltimore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1054 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jo Ann Owens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 15, 1945

8. AGE: Years	Months	Days	If less than one day
-	1	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Clayton Owens
13. Birthplace Morley, Tenn.

MOTHER
14. Maiden Name Retha Parker
15. Birthplace Morley, Tenn.

16 (a) Informant Mr. Clayton Owens
(b) Address 1054 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 14, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. Willis Hamerman
(b) Address 1003 W. Baltimore St.

19 (a) MAR 13 1945 Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1945, at 6.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to March 1945 and that I last saw her alive on March 11 1945.

Immediate cause of death	Duration
Meningocele (congenital)	
Due to	
Due to	
Other Conditions Paralysis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 752 W. Fayette St. Date signed

X

G26813 — BALTIMORE CITY HEALTH DEPARTMENT — G26813 Registered No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Anne Arundel
(c) City or town: Lothian
(If outside city or town limits, write RURAL and give town)
(d) Street No.: (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Hillary Blake

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife: Emma Blake
6 (c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): 1908

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace: Bristol A A Co Md.
(Town, county, and state)
10. Usual Occupation: Farm hand
11. Industry or business

FATHER
12. Name: Elisk Blake
13. Birthplace: Md

MOTHER
14. Maiden Name: Josephine Franklin
15. Birthplace: Md

16 (a) Informant: Nettie Blake
(b) Address: Lothian Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/45 (month) (day) (year)
(c) Cemetery or crematory: Moses
Location: Drury Md

18 (a) Funeral director: T A Hardesty & Son
(b) Address: Galesville Md

19 (a) MAR 13 1945 (Date received by registrar) Huntington Williamsburg, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 19 45, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw him alive on 3/10 19 45.

Immediate cause of death	Duration
Overwhelming toxemia	3 days
Due to Psoas abscesses, bilateral	1 month
Due to Osteomyelitis of Spine	5 months
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Helen A Horn M. D.
Address: University Hosp. Date signed 3/13/45

G26814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1946 F

G26814 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Riviera Apts Lake Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Ottenheimer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband ~~or wife~~ Joseph Ottenheimer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-13-76

8. AGE: Years 68 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER 12. Name Louis Morgenthal

13. Birthplace Ger.

MOTHER 14. Maiden Name Fanny Miller

15. Birthplace Ger.

16 (a) Informant Rebecca (JOHNS HOPKINS HOSPITAL)

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Balto. Hebrew

Location Balto. Md.

18 (a) Funeral director Harris Sonneborn & Son

(b) Address 1902 Eutaw Place

19 (a) (Date rec'd by Registrar) (b) Registrar

MAR 13 1945

Huntington Hollins

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1945 at 7:56 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 6 1945 to Mar. 12 1945 and that I last saw her alive on Mar. 12 1945.

	Duration
Immediate cause of death: ? Coronary Occlusion	Immediate
Due to: Coronary Sclerosis	2 yrs.
Due to:	
Other Conditions: Ca of Gall Bladder - ? 2 local metastases (Include pregnancy within 3 months of death)	
Date of operation 3/7/45	
Major findings of operation: Gall Bladder Fistula - Carcinoma.	
Date of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Mullen, Jr. M. D.
Address The J.H.H. Date signed 3-12-45

94a

815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V46E

Registered No. 606815

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 Lettitia av
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph MaTehis

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-07-6644

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	married

6 (b) Name of husband or wife Stella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Luth
(Town, county, and state)

10. Usual Occupation Sailor

11. Industry or business

FATHER
12. Name ?
13. Birthplace Luth

MOTHER
14. Maiden Name ?
15. Birthplace Luth

16 (a) Informant Stella Matehis
(b) Address 1913 Lettitia av

17 (a) Burial (b) Date thereof Nov 15-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Baltimore Md.

18 (a) Funeral director Joseph Kasmakas Jr
(b) Address 602 E Washington St Balt

19 MAR 1 1945 Hunstington Williams Mgr
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12-45, at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1945 to 3-12 1945 and that I last saw him alive on 3-12 1945

Immediate cause of death Cardiorespiratory failure — Duration

Due to Generalized carcinomatosis

Due to Carcinoma of colon

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-5-45

Major findings of operation: Inoperable ca. of colon

of autopsy: Not known yet

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene J. Lyons M. D.
Address Sinai Hospital Date signed 3-12-45

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

6816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 108

Registered No. G6681

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1810 E. 32nd Street
(c) Hospital or institution: 9-b
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 E. 32nd Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE LAURIE RULEY

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry D. Ruley

6 (c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1866

8. AGE: Years 78 | Months 7 | Days 3 | If less than one day ....hr. ....min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas M. Bryan
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Annie Glasby
15. Birthplace Baltimore, Md

16 (a) Informant Mr. Henry D. Ruley
(b) Address 1810 E. 32nd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) MAR 12 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION P. M.

20. DATE OF DEATH March 11, 1945, at 135 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 29 1945 to March 11 1945 and that I last saw her alive on March 11 1945

Immediate cause of death	Duration
(a) Cardiac Dilitation	2 hours
Due to (b) Pneumonia	2 wks
Due to (c) Primary Depression	4 days
Other Conditions	over 1

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward C. Zimmerman M. D.
Address 2858 Maryland Date signed 3/14/45

X

626817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30D

626817 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2029 N. Calvert (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sherman L. Justice

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-27-05

8. AGE: Years 40 | Months 1 | Days 15 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Printer

11. Industry or business

FATHER
12. Name Sidney Justice
13. Birthplace Md

MOTHER
14. Maiden Name Mary Sterling
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) 15 (day) 45 (year)
(c) Cemetery or crematory Leakin
Location Loudon Park Balto MD

18 (a) Funeral director Harry H. Hyde & Son
(b) Address 206 Main St, Lonaconing MD

19 (a) MAR 13 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 19 45 at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1945 to Mar 12 1945 and that I last saw him alive on Mar 12 1945

Immediate cause of death Respiratory obstruction — Duration

Due to Aortic aneurism

Due to 3° Syphilis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-10-45

Major findings of operation: Aneurism aortic arch

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Walter Mullen Jr. M. D.
Address The Johns Hop Hosp Date signed 3-12-45

VS 150

G60818 G60818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V164E

Registered No. .....

Use ink or indelible pencil. Make entries clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: University Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 Dumbarton ave.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME William E. Krebs

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #2	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 19th 1915

8. AGE: Years	Months	Days	If less than one day
29	3	23	..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Investigator
11. Industry or business O.P.A.

FATHER
12. Name Harry W. Krebs
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Cora Lee Walker
15. Birthplace Va.

16 (a) Informant Cora Lee Krebs
(b) Address 301 University Pkwy

17 (a) Burial (b) Date thereof 3/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Md

18 (a) Funeral director William Cook Inc.
(b) Address 317 St. Paul St

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12-1945, at 10:40 AM

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH .....
Crushed chest
Ruptured liver
Due to Broken bones
.....
Other Conditions .....
.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-12-45 at 8:30 A.M.
(b) Where did injury occur? O'Sullivan Bldg
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?
(d) Means of injury Jumped from 17th floor

23. Signature Thomas J. Mueller M.D.
Medical Examiner.
Date signed 3-12-45

VS 151

626819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

626819

Registered No. 1707

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Fort Howard (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard L. Jensen

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Single

6 (b) Name of husband or wife Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1899

8. AGE: Years	Months	Days	If less than one day
45	6	10	hr. min.

9. Birthplace Philadelphia, Penna (Town, county, and state)
10. Usual Occupation Soldier W Sal Roller
11. Industry or business Stainless Steel

FATHER
12. Name Jacob G. Jensen
13. Birthplace Germany

MOTHER
14. Maiden Name Adaline Miller
15. Birthplace Phila Pa

16 (a) Informant Jacob G. Jensen
(b) Address 1141 Clover Lane, Chester Pa. 24268

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 3-14-45 (month) (day) (year)
(c) Cemetery or crematory Harmony, Delaware Co
Location Upper Darby, Pa.

18 (a) Funeral director William Cook Inc
(b) Address 217 E Pauls St

19 (a) MAR 13 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1945, at 7 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/10/45 at Balto. Co. 10 P. M.
(b) Where did injury occur? Baer Creek & Wise Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Motorcycle into fixed object

23. Signature Robert Lee Graham M.D. (Medical Examiner.)
Date signed March 12 1945

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Clarence Peake 4508 Harford Rd Hamilton 726820

BALTIMORE CITY HEALTH DEPARTMENT

726820 **CERTIFICATE OF DEATH** 1248 Registered No.

—PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4806 Pilgrim Rd. Hamilton
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4806 Pilgrim Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Robert E. Lee Cooper

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or~~ wife: Carrie B. Cooper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 29th 1876

8. AGE: Years 68 | Months 2 | Days 17 | If less than one day hr. min.

9. Birthplace Harpers Ferry W. Va.
(Town, county, and state)

10. Usual Occupation Journeyman Painter

11. Industry or business S. A. Williams Co.

FATHER
12. Name Charles Cooper
13. Birthplace Unknown

MOTHER
14. Maiden Name America Rohrer
15. Birthplace W. Va.

16 (a) Informant Mrs Gloria Hansen
(b) Address 4806 Pilgrim Rd-Hamilton

17 (a) Burial (b) Date thereof 3/14/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 11th 1945, at 11:25 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20, 1944 to 3-11-1945 and that I last saw h[illegible] alive on 3-7-1945

Immediate cause of death	Duration
Hepatic Cirrhosis	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Peake M. D.
Address 1127 St. Paul Date signed 3-12-45

VS 150

G66821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G66821 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 Wheatsheaf St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Sydnor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	Black.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-9-45

8. AGE: Years	Months	Days	If less than one day
	1	3	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name James Sydnor.
13. Birthplace md.

MOTHER
14. Maiden Name Catherine Wheatley
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3/15/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West Post Rd.

18 (a) Funeral director Chas. H. Olepoda
(b) Address 92 [illegible] Mount St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12. 1945 at 10.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 12 1945 to March 12 1945, and that I last saw h~~im~~ alive on March 12 1945.

Immediate cause of death	Duration
Capillary	
Due to Bronchitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John R. Bunningham M. D.
Address JHH Date signed 3-13

VS 150

G26822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

G26822 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 624 S. Lehigh St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 624 S. Lehigh (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pasquale Vece

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Virginia Vece

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29 1869.

8. AGE: Years	Months	Days	If less than one day
76.	11	13	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Canton Railroad

FATHER — 12. Name Antonino Vece

13. Birthplace Italy

MOTHER — 14. Maiden Name Unknown

15. Birthplace Italy

16 (a) Informant Anthony Vece

(b) Address 624 S. Lehigh St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof March 14 1945 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Wendell Stengel

(b) Address 812 S. Lehigh St.

19 (a) (Date rec'd by registrar) (b) Wallington Williams Registrar

MAR 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1945, at 9.25 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Feb 1944 to March 10 1945, and that I last saw h[illegible] alive on March 9 1945.

Immediate cause of death	Duration
Cardio-Renal-Insufficiency	
Due to Hypertension	
Due to Old Age	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. S. Mann M. D.

Address 716 Cathedral St. Date signed 3-13-45

X

6.6823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1700 Registered No. 6.6823

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hr.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 N. Spring St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Robert Boyd

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12/6/1914

8. AGE: Years 30 31 | Months 2 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name John Boyd

13. Birthplace NC

MOTHER 14. Maiden Name Mareska Boyd

15. Birthplace NC

16 (a) Informant Estella Boyd

(b) Address 1804 N Spring St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location A. A. Co

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E Preston Street

19 (a) MAR 14 1945 (Date rec'd by reg.) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11- 1945, at 6 40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to Hemorrhage

Other Conditions Multiple fractures

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 14/3

(a) Date of injury 3-11-45 at 3.20 A.M.

(b) Where did injury occur? Northbd. S. of Druid Hill Ave

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Auto. Struck Safety Street Sylon

23. Signature Howard J. Madden M.D.
Medical Examiner.

Date signed 3-12-45

VS 151

X

AB-92452 G26824

BALTIMORE CITY HEALTH DEPARTMENT ✓ G26824

CERTIFICATE OF DEATH 74a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully secured. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 E. 22nd. 1/2 St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otis Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20-1938

8. AGE: Years	Months	Days	If less than one day
6	11	22	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Gus Price
13. Birthplace S.C.

MOTHER
14. Maiden Name Johnie Price
15. Birthplace S.C.

16 (a) Informant Baltimore City Hospitals-Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. G. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston Street

19 (a) (b)
Date received by Registrar Registrar

MAR 14 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1945, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7 1945, to 3-11 1945 and that I last saw him alive on 3-11 1945.

Immediate cause of death	Duration
acute Lymphoid Leukemia	3mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clifton W. Gordon Jr. M. D.
Address B.C.H. Date signed

Huntington Williams, M.D.

X

626825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

626825

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1.00
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Lafette Seefeldt

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION 30

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife —

6 (c) If alive, give age years

20. DATE OF DEATH March 12, 19 45, 6:47 M

7. Birth date of deceased (mo., day, yr.) About 1880

8. AGE: Years	Months	Days	If less than one day
About 64			hr. min.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

9. Birthplace Baltimore.
(Town, county, and state)

10. Usual Occupation Elevator Operater

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace U

MOTHER
14. Maiden Name U
15. Birthplace U

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

16 (a) Informant Self

(b) Address

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

17 (a) Burial (b) Date thereof 3-14-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave

18 (a) Funeral director Kendall E Humphreys
(b) Address 1701 E. Broadway

19 MAR 14 1945 (b)
(Date rec'd by registrar) Huntington W. Register, M.D.

23. Signature Robert A. Graham M.D.
Medical Examiner.
Date signed March 12 1945

VS 151

G26826

BALTIMORE CITY HEALTH DEPARTMENT

TH. 71185

CERTIFICATE OF DEATH 93D

Registered No. G26826

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-2-26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred Powers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12, 1872

8. AGE: Years 72 | Months 4 | Days 21 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name John Powers
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecca Winks
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 13 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 14 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3rd 1945 19..., at 11.55 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 19 42 to 3-3 19 45, and that I last saw him alive on 3-3- 19 45

Immediate cause of death: Coronary thrombosis fibrosis — Duration 5 min

Due to: Arterio sclerosis hypertension cardiac vascular disease

Due to

Other Conditions: Chronic bronchitis Pulmonary emphysema
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.

Address Baltimore City Hospitals Date signed 3-7-45

PLEASE WRITE PLAINLY, with unfading ink. Use typewriter if possible. Do not use pencil. Be sure to write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Information used for statistical purposes only. Be sure correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 6608

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ Hosp – Redwood and Greene St
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 553 W. Biddle St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Watts

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
50+			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 12 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 14 1945 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1945 at 11:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 1945 to 3-8 1945 and that I last saw h[illegible] alive on 3-8 1945

Immediate cause of death	Duration
Pneumonia	1½ Days
Left Lower Lobe	
Due to	
Due to	
Other Conditions Cerebrovasc accident	10 days
& right sided paralysis	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D Kleeron M. D.
Address Univ. Hospital Date signed 3-10-45

VS 150

2575

668828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 668828

CWK. 92004

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 42 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 737 S. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Juliander

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20-1881

8. AGE: Years	Months	Days	If less than one day
63	8	13	hr. min.

9. Birthplace Finland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles Juliander (D)
13. Birthplace Finland

MOTHER 14. Maiden Name Mary Sharpe (D)
15. Birthplace Finland

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern Ave. Balto.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL MAR 13 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 14 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3- 1945 at 4- P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7- 1945 to 3-3- 1945 and that I last saw him alive on 3-3-45 1945.

Immediate cause of death	Duration
Pneumonia	7
Lobular Hemorrhagic	2 wks.
Due to	
Due to	
Other Conditions Arterio Sclerotic heart disease	7

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C Woodward M. D.
Address Baltimore City Hospitals Date signed 3-3-45

Please write clearly, using ink. Physicians: please write the causes of death clearly and legibly. Information required in items 1 to 23 is especially important.

F-377

X

6268.23 ✓ 6268.23

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp'l
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4911 Eastern Av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Hill

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 113-03-4615

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1898

8. AGE: Years	Months	Days	If less than one day
46	8	12	hr. min.

9. Birthplace Wuvrat, Finland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Wagonmaker Bros.

FATHER
12. Name Gabriel Majemaki
13. Birthplace Finland

MOTHER
14. Maiden Name Olga ?
15. Birthplace Finland

16 (a) Informant Mrs. Lillie Hill Zoramsky
(b) Address 3425 W. Adams Blvd.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 3/15/45 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location Frederick ave

18 (a) Funeral director H. Sanders & Sons Inc
(b) Address North ave & Broadway

19 (a) MAR 14 1945 (Date rec'd by registrar) (b) Registrar

Hunting for Williams, MS

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18/45 12:15 PM

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph B. McNally Medical Examiner.

Date signed 2/18/45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

060268 30
6268.0

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. 6268

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 719 E. 20th Street
(c) Hospital or institution:
9-d
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 719 E 20th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH ANNA BOZMAN

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Wesley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1870

8. AGE: Years 74 | Months 8 | Days 23-29 | If less than one day hr. min.

9. Birthplace Oriole, Md
(Town, county, and state)

10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Thomas Smith
13. Birthplace Oriole, Md

MOTHER
14. Maiden Name Katherine Phoebus
15. Birthplace Oriole, Md.

16 (a) Informant Mrs. C.H. McDaniel
(b) Address 2901 Evergreen Avenue

17 (a) burial (b) Date thereof 3-15-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore, Gen.
Location Baltimore, Md

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 MAR 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 45 19 , at 12.10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 19 44 to 3-12 19 45, and that I last saw h[illegible] alive on 3-12 19 45.

Immediate cause of death: Myocardial Degeneration — Duration 14 yr.
Due to: Arteriosclerosis
Due to:
Other conditions: Cardiac Failure
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed [illegible]

G66831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G66831 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4603 ParkHeights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4603 ParkHeights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Birnbaum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1883

8. AGE: Years 61 | Months 9 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business: House Work

FATHER
12. Name: Felix Slusky
13. Birthplace: Russia

MOTHER
14. Maiden Name: Ida Selenkow
15. Birthplace: Russia

16 (a) Informant: Isaac Birnbaum
(b) Address: 4603 Parkheights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 14, 1945 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Friendship Cem
Location: E. Baltimore St

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124 1126 W North Ave

19 (a) Date received by Registrar: MAR 14 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13/ 1945 at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1928 to 3/13 1945.
and that I last saw h.C.R alive on March 13 1945.

	Duration
Immediate cause of death: Hypertensive Cardiovascular	16 yrs
Due to: Myocarditis	16 yrs
Due to: Decompensation	1-2 yrs
Other Conditions: Broken Femur - 2 days	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dlayd A Weinstock M. D.
Address 536 N Kk Hts ave Date signed 3/13/45

G26832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 c

G26832 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. + Linden Ave
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos and 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3101 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Baer

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1882

8. AGE: Years	Months	Days	If less than one day
62	8	28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business Justine Inc.

FATHER
12. Name Henry Baer
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Klein
15. Birthplace Germany

16 (a) Informant Miss Emma M. Baer
(b) Address 3101 Walbrook Ave.

17 (a) Burial (b) Date thereof 3/15/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 14 1945 Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13 1945, at 7.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22 1945, to 3/13 1945, and that I last saw her alive on 3/12 1945.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Rheumatic C. V. Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Genl. Hospital Date signed 3/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G66833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G66833

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Fairfield MD
(b) Street address Bethlehem-Fairfield Shipyard
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Claude E. Brown.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-61-1961

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Emma B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 61? | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Stationary Engineer

11. Industry or business

FATHER
12. Name James T. Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Nora
15. Birthplace Md.

16 (a) Informant Emma B. Brown
(b) Address 210 N Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/45 (month) (day) (year)
(c) Cemetery or crematory Chester Cem
Location Chestertown Kent Co.

18 (a) Funeral director Edward Foulger
(b) Address 2359 Edmondson Ave Baltimore, Md.

MAR 14 1945 (Date rec'd by registrar)
(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12 1945, at 8:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. F. Jelenko M.D. (Medical Examiner.)
Date signed 3/12/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

626834 BALTIMORE CITY HEALTH DEPARTMENT X ✓ 626834
CERTIFICATE OF DEATH 170c Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Pikesville #9
(If outside city or town limits, write RURAL and give town)
(d) Street No. Smith ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Winifred Beckham Wyse

3 (b) If veteran, name war —

3 (c) Social Security Account No. No

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Wm P. S. Wyse, M.D.

6 (c) If alive, give age [redacted] years

7. Birth date of deceased (mo., day, yr.) Dec 9-1868

8. AGE: Years 76 | Months 2 3 | Days 23 3 | If less than one day ..... hr. ..... min.

9. Birthplace Bardstown, Kentucky
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William L. Beckham
13. Birthplace Bardstown, Kentucky

MOTHER
14. Maiden Name Julia J. Wycliff
15. Birthplace Baton Rouge, Louisiana

16 (a) Informant Wycliffe Wyse
(b) Address Smith Ave. Pikesville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md

18 (a) Funeral director Frank H. Purnell
(b) Address Pikesville, Maryland

19 (a) Date received by registrar MAR 14 1945 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12- 1945, at 6.20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection + Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Multiple fractures, lacerations, contusions.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-12-45 at Balto. Co. 6.05 P.M.
(b) Where did injury occur? Register ave. & York Road
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Collision with automobile

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 3-12-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26835 X ✓ G26835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore County
(If outside city or town limits, write RURAL and give town)
(d) Street No. Smith ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME W. P. F. Wyse, M. D.

3 (b) If veteran, name war —

3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Minnie O. -

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 2-1867

8. AGE: Years	Months	Days	If less than one day
77 78	98	10	hr. min.

9. Birthplace Baltimore, County, Maryland
(Town, county, and state)

10. Usual Occupation Medical Doctor

11. Industry or business

PARENTS

FATHER
12. Name Francis D. Wyse
13. Birthplace Baltimore, County, Maryland

MOTHER
14. Maiden Name Mary Elizabeth Pope
15. Birthplace Augusta, Maine

16 (a) Informant Wickliffe Wyse
(b) Address Smith Ave. Balto. 6, Md

17 (a) Burial (b) Date thereof 3/14/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Frank H. Mitchell
(b) Address Pikesville, Maryland

19 (a) MAR 14 1945 (b) 14 Huntington
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12- 1945 at 6.05 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock

Due to

Other Conditions Fractured ribs & forearm
Laceration abrasion & bruised brain
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-12-45 at Balto. Co. 6.05 P.M.,
(b) Where did injury occur? Register Ave. & York Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Collision with automobile

23. Signature Howard J. Mesmer M.D.
Medical Examiner.
Date signed 3-12-45

VS 151

6836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 6266836

1. PLACE OF DEATH: 3557 Eaton Ave.
(a) Baltimore City, Maryland
(b) Street address 3551 Eaton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3551 Eaton Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? 50- years

3 (a) FULL NAME Margaret Lehman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frank K. Lehman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30th 1869

8. AGE: Years 75 | Months 4 | Days 12 | If less than one day 14 hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John Christ
13. Birthplace Germany

MOTHER
14. Maiden Name Margaretha Hess
15. Birthplace Germany

16 (a) Informant Katherine Rumpf
(b) Address 3551 Eaton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 17, 1945 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Fredk. Ave. Balto. Md.

18 (a) Funeral director Dill Bros.
(b) Address 3109 Frederick Ave.

19. (a) MAR 17 1945 (Date rec'd by registrar) Huntingtn Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1945, at 9:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1939, to 3/13 1945. and that I last saw her alive on March 12 1945

Immediate cause of death Pneumonia Thrombosis — Duration 5 days

Due to General Arteriosclerosis — 5 yrs

Due to Diabetes Mellitus — 25 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elliot W. Johnson M. D.
Address 3432 Frederick Ave Date signed 3/14/45

VS 3

JL - 92205 G26837 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 57B

Registered No. G26837

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 304 N. Arlington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1866

8. AGE: Years	Months	Days	If less than one day
78	10	24	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Williams
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 15, '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. William
(b) Address 122 N. Schroeder St.

19 MAR 14 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 1945, at 7.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 19 1945, to Mar. 10 1945, and that I last saw him alive on Mar. 10 1945.

Immediate cause of death: Pneumonia — Duration: 2 days

Due to: Uremia — Duration: 1 week

Due to: Carcinoma of Prostate — Duration: ?

Due to: Hydronephrosis — Duration: ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-9-45

Major findings of operation: Severe Cystitis greatly enlarged Prostate

of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. J. Perry M.D.
Address BCH Date signed 3-11-45 M. D.

X

AB-92047 G26838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122

Registered No. G26838

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos-2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otho Conyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife Alice (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12-1870

8. AGE: Years	Months	Days	If less than one day
74	2	30	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name David Conyer (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Maria Bolden (D)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Mar. 15, '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

MAR 14 1945 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11- 1945, at 4.24 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-9- 1945 to 3-11 1945, and that I last saw him alive on 3-11- 1945.

Immediate cause of death	Duration
Peritonitis	one day
Toxemia	"
Due to Stenosis of urinary bladder & perforation	"
Due to Incarcerated Hernia	years
Other Conditions Arteriosclerosis Pulmonary Edema	" hours

(Include pregnancy within 3 months of death)

Date of operation 3-10-45
Major findings of operation: above
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town). (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. M. Cunningham M. D.
Address Balto City Hosp - Date signed 3-12-45

G26839 ✓ G26839

TN. 91918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 and 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 N. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad Waller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3rd, 1892

8. AGE: Years	Months	Days	If less than one day
52	10	9	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James G. Waller
13. Birthplace Virginia

MOTHER
14. Maiden Name Agnes Reed
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (records

17 (a) Removal (b) Date thereof Mar. 14 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Shipped to
Location Fredericksburg Virginia

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 MAR 14 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12th, 1945 3.30 A.M at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2nd, 1945 to Mar 12th 1945 and that I last saw h im alive on Mar 12th 1945

Immediate cause of death	Duration
Pneumonia	24 hrs
Cerebrovascular accident	72 hrs
Due to Cardiac decompensation	6 mo
Due to Arteriosclerosis + Hypertension ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 3-5-45

Major findings of operation: Arteriosclerotic gangrene of Rt leg

of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E J Perry M.D.

Address 12 C St Date signed M. 3-13-45 D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

6840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G26840 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 Myrtle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Lee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife Richard Lee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Baltimore, md. (Town, county, and state)
10. Usual Occupation Maid
11. Industry or business

FATHER
12. Name Andrew J. Reed
13. Birthplace Va.

MOTHER
14. Maiden Name Anna Credith
15. Birthplace md

16 (a) Informant Milton B. Reed
(b) Address 1316 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brentley ave

19 (a) (Date rec'd by registrar) (Huntingtown Williams MD Registrar)

MAR 14 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 1945, at 7 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5/45 19 to 3/12 1945, and that I last saw h alive on 3/12 19 45.

Immediate cause of death: Cirrhosis of Liver — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cirrhosis of Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Berry, M.D.
Address Provident Hospital Date signed 3/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G2684-1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 13B

G2684-1 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1621 Lancaster ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 Lancaster ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ollie Stoneberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years 34 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James A. Bates
13. Birthplace Loury, Va.

MOTHER 14. Maiden Name Maggie ?
15. Birthplace Va.

16 (a) Informant Avis Campbell
(b) Address 1644 E. Pratt St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 3-14-45 (month) (day) (year)

(c) Cemetery or crematory
Location Elkton Va.

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS Form 10 MAR 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12 1945 6:05 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lubrecki M.D.
Medical Examiner.

Date signed 3/13/45

G26842 BALTIMORE CITY HEALTH DEPARTMENT X G26842
CERTIFICATE OF DEATH 137B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Edgemere Md.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2617 Edgemere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andy Driver

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-000

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth Driver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
59	3 mo	13	hr. min.

9. Birthplace Transylvania, Hungary (Town, county, and state)
10. Usual Occupation Steel worker
11. Industry or business

FATHER
12. Name Mike Driver
13. Birthplace Transylvania, Hungary

MOTHER
14. Maiden Name Julia Bartha
15. Birthplace Transylvania, Hungary

16 (a) Informant Patient
(b) Address 2617 Edgemere Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 3-16-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director John C Miller Inc
(b) Address 2435 Eastern Ave

19 (a) MAR 14 1945 (Registrar's signature) Huntingdon Pennsylvania

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13 1945 at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31 1945 to 3-13 1945 and that I last saw him alive on 3-13 1945

Immediate cause of death Uremia — Duration 14 days
Staphylococcus septicemia
Due to Prostatic abcess
+ Pyelonephritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 2-28-45
Major findings of operation: Large prostatic abcess
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Steven Hatch, M. D.
Address C.H.H. Date signed 3-13-45

X

G26843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G26843 Registered No. 96 British Seaman

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: S.S. Empire Mauritius
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SK HASSON SK ALLEE

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace Retnagiri India (Town, county, and state)

10. Usual Occupation Marine

11. Industry or business SS Empire Mauritius Merchant

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Fatch Ali Courani
(b) Address Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Wyndenne Md

18 (a) Funeral director Wilson Cook Inc
(b) Address 1324 E Cold St

19 (a) MAR 1945 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11- 1945, at 7 53 AM

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intra pericardial Hemorrhage, Aortic aneurism

Due to Ruptured aorta

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 3-12-45

Huntington Hillsenrath MD

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL - 92533 G26844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No. G26844 (over)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940m Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 N. Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Cornell

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25, 1868

8. AGE: Years 55 52 | Months 10 | Days 17 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Lewis
13. Birthplace Bohemia

MOTHER
14. Maiden Name Annie
15. Birthplace Bohemia

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Fairplay Md

18 (a) Funeral director Wilhom Funeral Home
(b) Address 1217 E. Fort Ave

19 (a) (Date received by registrar) (b) Lington Williams, M.D. Registrar

MAR 14 1945

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 12 1945, at 12 Mdt M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 12 1945, to Mar. 12 1945, and that I last saw her alive on Mar. 12 1945.

Immediate cause of death Anemia, secondary to bleeding from G.I. tract (bleeding ulcer?) — Duration ?

Due to

Due to

Other Conditions Lobar pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Rey, Jr. M. D.
Address City Hosp Date signed 3-12-45

1172

G26845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G26845

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2818 Presstman St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. LELIA F. CHEETHAM

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/8/1868

8. AGE: Years	Months	Days	If less than one day
77	1	5	hr. min.

9. Birthplace Virginia (town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Rappold
13. Birthplace Virginia

MOTHER
14. Maiden Name Lelia Sharples
15. Birthplace Virginia

16 (a) Informant Mrs. Edwina Reilly
(b) Address 2818 Presstman St.

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 3/16/45 (month) (day) (year)
(c) Cemetery or crematory Westerns
Location Baltimore Md

18 (a) Funeral director Tilton & Son
(b) Address 2104 Pool

19 (a) 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13 1945, at 8 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12 1945 to 3/13 1945, and that I last saw h[illegible] alive on 3/13 1945

Immediate cause of death	Duration
Cardiac Failure	
Due to [illegible]	
Due to Overwhelming Lobar Pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter F. Speleky M. D.
Address Mercy Hosp. Date signed 3/13/45

G26846 G26846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1640

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 S. Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo Hagan

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-9467

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Carmie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1899

8. AGE: Years	Months	Days	If less than one day
45	4	10	hr. min.

9. Birthplace Rockville, Md.
(Town, county, and state)
10. Usual Occupation Construction Engineer
11. Industry or business U. S. Coast Guard

FATHER
12. Name Joseph Hagan
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine McCarthy
15. Birthplace Va

16 (a) Informant Carmie Hagan
(b) Address 3754 W. Franklin St.

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 3/15/45 (mo.) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Wilhorn & Colvine
(b) Address 1241 E. Pratt St.

19 (a) 3 9045 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 - 1945, at 9A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions Despondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-12-45 at 24/2 8:35 A M.
(b) Where did injury occur? 1101 Key Highway - Harbor
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Drowning

23. Signature Howard A. Nelsen M.D.
Medical Examiner.
Date signed 3-12-45

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G26847

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. Balto. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 302 Westfield Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward G Libertini

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Carolina A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14 - 1881

8. AGE: Years 63 | Months 7 | Days 29 | If less than one day hr. min.

9. Birthplace Italy (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name James Libertini

13. Birthplace Italy

MOTHER 14. Maiden Name Josephine Severina

15. Birthplace Italy

16 (a) Informant Mrs Caroline A. Libertini

(b) Address 302 Westfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-45 (month) (day) (year)

(c) Cemetery or crematory Moreland Pk.

Location Baltimore

18 (a) Funeral director Leonard J. Luck

(b) Address 5809 Harford Rd.

19 (a) MAR 14 1945 (Date rec'd by registrar) Registrar

Harry L. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13 1945, at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13 1945, to 3-13 1945, and that I last saw him alive on 3-13 1945.

Immediate cause of death Pulmonary edema — Duration

Due to myocardial insufficiency

Due to Coronary artery disease

Other Conditions old myocard. infarct. c P C Linen.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: no other

of autopsy: no other

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert Farber M. D.

Address Sinai Hosp. Date signed 3-13-45

VS 150

X

Dr Boyle

626848

626840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 A Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3009 Roystone Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 Royston Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Adam Kircher

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Mary M (Ward)
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 13-1881
8. AGE: Years 64 Months Days If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Antop Kircher
13. Birthplace Balt. Md.

MOTHER
14. Maiden Name Virginia Smith
15. Birthplace Balt. Md.

16 (a) Informant Margaret L. Kircher
(b) Address 3009 Royston Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-45 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Baltimore

18 (a) Funeral director J. Kemp
(b) Address 5306 Harford Rd

19 (a) MAR 14 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 13 1945, at 10.8 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943, to Mar. 13 1945, and that I last saw him alive on Mar. 11 1945.

Immediate cause of death: Carcinoma of Esophagus — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Burke Boyle. M. D.
Address 5217 Harford Rd Date signed 3/14/45

VS 180

G26849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162B

G26849 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton and Wilkens Ave

(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital (or inst. (yrs., mos., or days) 1/28/44

(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Roland & Belvedere Aves. (If rural give location)

(e) Citizen of foreign country? ------- (Yes or No)

If yes, name country -------

3 (a) FULL NAME Father Francis Hafey (Francis P. Havey)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ---------

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ---------1865

8. AGE: Years 80 | Months --- | Days -- | If less than one day ____hr. ____min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Roman Catholic Priest

11. Industry or business ---------

FATHER 12. Name Patrick Havey

FATHER 13. Birthplace Ireland

MOTHER 14. Maiden Name Elizabeth Duegnan

MOTHER 15. Birthplace Ireland

16 (a) Informant St. Mary's Seminary Record

(b) Address Roland & Belvedere Avenues

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/45 (month) (day) (year)

(c) Cemetery or crematory St. Charles College

Location Catonsville, Md.

18 (a) Funeral director H. W. Mears and Son

(b) Address 805 N. Calvert Street

19 (a) APR 1 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13 1945 at 5:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/4 1945 to 3/13 1945 and that I last saw h[illegible] alive on 3/13 1945

Immediate cause of death Respiratory failure — Duration

Due to Pulmonary Edema due to cardiac failure

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H Williams J Bryan M. D.

Address St. Agnes Hosp Date signed 3/13/45

VS 150

G26830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183a

G26830 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --------
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2704 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME JOHN L. BROWN (John Leo Brown)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife --------

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) -------- 1885

8. AGE: Years 60 | Months -- | Days -- | If less than one day -- hr. --- min.

9. Birthplace N. B Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Checker for

11. Industry or business Bethlehem - Fairfield

FATHER
12. Name Daniel J. Brown
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Murray
15. Birthplace Ireland

16 (a) Informant Miss Nannie G. Brown
(b) Address 2745 N. Calvert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meeks and Son
(b) Address 805 N. Calvert Street
MAR 14 1945 Huntingdon Williams, M.D.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 1945, at 630P M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial Hematoma, spontaneous

Due to Vascular aneurysm

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Roland Lee Grafton M.D. Medical Examiner.
Date signed March 13 1945

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26851 G26851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~yrs.~~, mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 71 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 St. Paul St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ------

3 (a) FULL NAME Mrs. John Marion Fountain (Effie Jean Fountain)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Mr. J. M. Fountain
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1873

8. AGE: Years	Months	Days	If less than one day
71	3	13 21	— hr. — min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Kelly Foster
13. Birthplace Maryland

MOTHER
14. Maiden Name Rachel Cox
15. Birthplace Maryland

16 (a) Informant J. Marion Fountain
(b) Address 3006 St. Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director H. W. Meeks and Sons
(b) Address 805 N. Calvert Street

19 (a) 1945 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14 1945, at 1:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1945 to 3/14 1945 and that I last saw h[illegible] alive on 3/13 1945

Immediate cause of death Cardio-Respiratory Failure — Duration

Due to Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, III M. D.
Address Union Memorial Hospital Date signed 3/14/45

VS 150

G26852 — BALTIMORE CITY HEALTH DEPARTMENT — G26852

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Cold Spring Lane
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Tomlinson Zepp

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife: Emma Zepp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24-1864

8. AGE: Years 81 | Months 1 | Days 19 | If less than one day hr. min.

9. Birthplace Westminster, Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Coldspring Nursing Home
(b) Address 2101 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 15-1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Johns
Location Ellicott City, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) MAR 14 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1945, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1943 to March 13 1945; and that I last saw him alive on March 13 1945.

Immediate cause of death: cerebral hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Cutterman, M.D.
Address 2324 Riordan Rd. Date signed 3/14/45

VS 150

G26853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 98

G26853

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution St Josephs Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ——
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 518 S. Regester St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta Haley

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: F

5. Color or race: W

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: M

6 (b) Name of husband or wife: FREDERICK HALEY

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): AUG. 17 1869

8. AGE: Years: 75 | Months: 6 | Days: 23 | If less than one day: 26 hr. ____ min.

9. Birthplace: BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation: HOUSE WIFE

11. Industry or business: AT HOME

FATHER
12. Name: UNKNOWN
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: GERMANY

16 (a) Informant: EDWARD HALEY (SON)
(b) Address: 1115 ENSOR ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 15/45 (month) (day) (year)
(c) Cemetery or crematory: TRINITY CEM.
Location: ODONNELL ST.

18 (a) Funeral director: Lilly Fowler Co
(b) Address: 403 S. WOLFE ST.

19 (a) MAR 14 1945 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1945 at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1945 to March 12 1945, and that I last saw her alive on March 12 1945.

Immediate cause of death: Toxemia - Dehydration — Duration

Due to: Arteriosclerosis

Due to: Gangrene of extremity Left foot

Other Conditions: Senility Emaciation Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: A M Bacon Jr M. D.
Address: St Josephs Hospital Date signed 3-12-45

X

G26854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G26854 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 E. 41st St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 601 E. 41st. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha E. Summers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widow

6 (b) Name of ~~husband or wife~~ Wm. E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 7 1870

8. AGE: Years	Months	Days	If less than one day
75	2	4	hr. min.

9. Birthplace Charles Co Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm. J. Summers
13. Birthplace Charles Co Md

MOTHER
14. Maiden Name Martha E. Persell
15. Birthplace Va

16 (a) Informant Hellen M. Summers
(b) Address 601 E 41st St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 16/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Road

18 (a) Funeral director John G Nolan
(b) Address 3000 E Baltimore St

19 (a) MAR 14 1945 (Date Rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6 1942 to Mar. 11 1945 and that I last saw h[illegible] alive on Mar. 11 1945

Immediate cause of death	Duration
Left ventricular failure	1 day
Due to Chr. myocarditis arteriosclerosis	5 yr.?
Due to Hypertension	
Other Conditions Gastric hemorrhage	3 yrs ago

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leo Schlenger

Address 4600 Liberty Hgts Ave Date signed 3/13/45 M. D.

Leo Schlenger

G26855 BALTIMORE CITY HEALTH DEPARTMENT G26855

CERTIFICATE OF DEATH V186a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Franklin Square Hosp.
(c) Hospital or institution: Fayette & Calhoun
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4632 Sekenley Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME William N. White (William Howard White)

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Viola B. White
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) July-9-1865

8. AGE: Years 79 | Months 8 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. County (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Wm. White
13. Birthplace Md.

MOTHER
14. Maiden Name Rachael Norris
15. Birthplace Md.

16 (a) Informant Mrs. W. H. White (wife)
(b) Address 4632 Sekenley Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. Md.

18 (a) Funeral director Stewart Mortuary Co.
(b) Address 108 W. Lanvale

19 (a) (Date received by Registrar) Huntington Williams, M.D. Registrar

MAR 14 1945

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1945, at 3 00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28 1945 to 3-14 1945, and that I last saw him alive on 3-14 1945

Immediate cause of death: Bronchopneumonia — Duration: 1 wk.

Due to:

Due to: Generalized arteriosclerosis & senility — 3 mo.

Other Conditions: Fracture neck of femur - Rt.

(Include pregnancy within 3 months of death)

Date of operation: Cast.

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: Accident 3/14
(b) Date of occurrence: 1-28-45
(c) Where did injury occur? Baltimore (City or town) (County) (State) M
(d) Did injury occur about home, on farm, industrial place, in public place? Sidewalk near home (Specify type of place) While at work? No
(c) Means of injury: Slipped on ice

23. Signature J. Carl Myers
Address Franklin Sq. Hosp. Date signed 3/14/45 M. D.

Approved by Howard J. Malden, M.D.

626856 626856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mount Hope Retreat 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 yrs 7 mos 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs 8 mos 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Mount Hope Retreat (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Sister M. Catherine Schaarmann (Mary Lilly)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 13, 1863

8. AGE: Years	Months	Days	If less than one day
82	1	27	14 hr. 25 min.

9. Birthplace Martinsburg, W. Va. (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name Philip Schaarmann
13. Birthplace Germany

MOTHER
14. Maiden Name Helen Nicholson
15. Birthplace Baltimore, Md.

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Road

17 (c) Cremation (Burial, cremation, or removal) (b) Date thereof 3-15-45 (month) (day) (year)
(c) Cemetery or crematory Mt Hope Cemetery
Location 6420 Reisterstown Rd
18 (a) Funeral director Sherwood Monroe
(b) Address 1818 Madison Ave

MAR 14 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1945, at 2:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1937, to 3/13 1945, and that I last saw h.er alive on March 13 1945.

Immediate cause of death	Duration
Repeated Miocardial Infarctions	1 year
Due to	
Due to	
Other Conditions Involutional Psychosis	36 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature L. Palagia M. D.
Address 326 Biddle St Date signed

X

G26857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G26857 / 83a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 846 W. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 846 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nimrod T. Burke

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary A. Burke
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) July 9, 1863

8. AGE: Years	Months	Days	If less than one day
81	8	4	hr. min.

9. Birthplace Prince George County, Md. (Town, county, and state)
10. Usual Occupation Retired - Farmer
11. Industry or business

FATHER
12. Name Levi F. Burke
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth M. Campbell
15. Birthplace Maryland

16 (a) Informant Mrs. Mary A. Burke
(b) Address 846 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 15, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director Miller Funeral
(b) Address 1005 W. Baltimore St.

MAR 14 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1945, at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 11 1945 to Mar 13 1945, and that I last saw him alive on Mar 13 1945.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. Pettet M. D.
Address 817 Hamilton Terrace Date signed

G26858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

G26858 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1629 N. Montford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto (b) County
(c) City or town Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 N. Montford Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Wm H. Jones Jr
3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 17th 1920

8. AGE: Years 24 | Months 11 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None Cripple

11. Industry or business

FATHER
12. Name Wm Jones Sr
13. Birthplace Md

MOTHER
14. Maiden Name Sarah V Harris
15. Birthplace Md

16 (a) Informant Mr. Wm Jones
(b) Address 1629 N Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15 1945 (month) (day) (year)
(c) Cemetery or crematory
Location Laytonsville Md

18 (a) Funeral director Leo S. Brook
(b) Address 701-03 N. Patterson Park Ave

19 (a) MAR 16 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14th 1945, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1944 to 3-14 1945, and that I last saw h[illegible] alive on 3-14 1945.

Immediate cause of death	Duration
Mitral Regurgitation	6 mo
Due to	
Due to Myocardial Degeneration	4 day
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? No While at work? (Specify type of place)
(e) Means of injury

23. Signature Darrell Miller
Address 1500 N Bdway Date signed M. 3 D. 15 45

VS 3

X

G26859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G26859 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Women's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3822 Greenmount
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LaVonne Lee White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/2/45

8. AGE: Years | Months | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Leslie Arnold White

FATHER 13. Birthplace Ashland, Kentucky

MOTHER 14. Maiden Name Florence Tackett

MOTHER 15. Birthplace Ashland, Kentucky

16 (a) Informant Mrs Leslie White

(b) Address 3822 Greenmount Ave Balto

17 (a) Burning (b) Date thereof 3/14/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Russell Sty

Location

18 (a) Funeral director Wm J Tickner & Sons

(b) Address N & Pk Ave

19 (a) 1945 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14 1945, at 1 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h. L. alive on 1 p.m. 3/14/45.

Immediate cause of death PNEUMONIA — Duration

Due to Aspiration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Autopsy — NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest E. Sanford M.D.

Address Woman's Hosp. Date signed 3/14/45

X

G26860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

G26860 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Carroll
(a) State Md. (b) County Baltimore
(c) City or town Manchester
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Amanda Laister

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Raymond Everett Laister
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1893

8. AGE: Years	Months	Days	If less than one day
51	4	16	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Jacob H Gummel
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Yingling
15. Birthplace Maryland

16 (a) Informant RAYMOND LEISTER
(b) Address MANCHESTER, MD

17 (a) BURIAL (b) Date thereof 3/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MANCHESTER
Location MANCHESTER, MD.

18 (a) Funeral director J. FRANCIS REESE
(b) Address WESTMINSTER, MD.

19 (a) MAR 5 1945 (b)
(Date received by registrar) (Registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1945, at 4:39 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1945 to March 14 1945, and that I last saw h alive on March 14 1945.

Immediate cause of death	Duration
Cardio - Pulmonary Failure	
Due to Generalized Carcinoma	
Due to Adenocarcinoma of Uterus	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alfred C Hutchinson M. D.
Address 2052 340 St Date signed 3-16-45

626861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1172 Registered No. 626861

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County KENT
(c) City or town Chestertown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Alexander Herzberg

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13 1878

8. AGE: Years	Months	Days	If less than one day
66	6	2	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation MERCHANT
11. Industry or business Grocery Store

FATHER
12. Name
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MAR. 19 1945 (month) (day) (year)
(c) Cemetery or crematory Chester
Location Chestertown, Md

18 (a) Funeral director J. Willis Wells
(b) Address Chestertown, Md

19 (a) MAR 15 1945 (Date rec'd by registrar) Hattie [illegible] Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1945 at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21 1945 to 3-15 1945
and that I last saw h[illegible] alive on 3/15/1945.

Immediate cause of death	Duration
(a) Cardiac failure Respiratory	
Due to (b) Cerebral Embolism	
Due to (c)	
Other Conditions Hyp Degeneration Probably	

(Include pregnancy within 3 months of death)

Date of operation 3/10/45

Major findings of operation: Ruptured peptic ulcer with partial obstruction

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cliff Routh, Jr. M.D. M. D.
Address St. Agnes Hosp Date signed 3/15/45

VS 150

61

G26862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94

G26862 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5120 Craig Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5120 Craig Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick J. McLernon

3 (b) If veteran, name war: 1D
3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife: Mary A. McLernon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30 ~~th~~ 1864

8. AGE: Years: 80 | Months: 4 | Days: 12 | If less than one day: hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name William McLernon
13. Birthplace Ireland

MOTHER 14. Maiden Name Margaret McDonald
15. Birthplace Ireland

16 (a) Informant Edw. M. McLernon (Son)
(b) Address 1501 Argonne Drive

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/15/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 MAR 15 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 12 ~~th~~ 1945, at 5 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-21- 1944 to 3-12 1945 and that I last saw him alive on 3-12 1945.

Immediate cause of death	Duration
CORONARY Artery Disease	?
Due to Degenerative changes	?
Due to of the Age-	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Anthony F. Bruzza, M.D.
Address 5215 York Rd. Date signed 3/13/45

G26863 BALTIMORE CITY HEALTH DEPARTMENT X 3/1 G26863

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Heights Ave.,
(c) Hospital or institution:
Alberta Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Timonium
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James T. Harmon

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25,1861

8. AGE: Years	Months	Days	If less than one day
83	10	17	hr. min.

9. Birthplace Frostburg, Penna.
(Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business Johns Hopkins University

FATHER
12. Name John Harmon
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecca Pierce
15. Birthplace Maryland

16 (a) Informant Mrs. Nellie C. Foard
(b) Address Riderwood, Maryland

17 (a) Burial (b) Date thereof Mar.15,1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bosley's
Location Baltimore C. Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 MAR 15 1945 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944 to 3/12 1945, and that I last saw h[illegible] alive on 3/12 1945

Immediate cause of death — Duration
Uremia
Due to Paroxysmal Atrial Disease
Due to Arteriosclerosis
Other Conditions Complications
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. D. Volenick M.D.
Address 4710 Liberty Hts. Date signed 3/13/45

G26864

JL - 91735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47D

Registered No. G26864

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
4940 Eastern Ave.
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Forrest St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Stone Gustaborder

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1889

8. AGE: Years 56 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation Unknown
11. Industry or business

FATHER
12. Name Frederick Gustaborder
13. Birthplace Pa.

MOTHER
14. Maiden Name Margaret McGinnis
15. Birthplace Pa.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Removal (b) Date thereof 3/15/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bellwood.
Location Pa

18 (a) Funeral director William Cook Inc
(b) Address 1817 St. Paul St

19 (a) MAR 15 1945 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1945, at 7.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 22 1945 to Mar. 9 1945, and that I last saw h im alive on Mar. 9 1945.

Immediate cause of death: Massive Hemoptysis — Duration: 5 min

Due to: Carcinoma of the Lung? — ?

Due to: Generalized pneumonia — 2½ months

Other Conditions: Atelectasis Left Lower Lobe. — 2 months
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospitals Date signed 3-16-45

X

26865 Cockey ✓ 26865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 109

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 W. Lombard st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William T Cockey

3 (b) If veteran, name war W
3 (c) Social Security Account No. [illegible]

4. Sex Male
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Thelma Cockey
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) May 1882
8. AGE: Years 62 Months 10 Days If less than one day ....hr. ....min.
9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Packages Painter
11. Industry or business Egg Inspector
FATHER 12. Name Dr. Charles W. Cockey
13. Birthplace Balto. Co. Md.
MOTHER 14. Maiden Name Amelia W. Henkel
15. Birthplace Balto. Md.
16 (a) Informant Amy Hunter
(b) Address 808 Madison Ave
17 (a) Burial (b) Date thereof 3/15/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto Md.
18 (a) Funeral director William Cook Inc
(b) Address 1917 St. Paul St.
19 (a) MAR 15 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12 1945, at 4.30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1945, to 3/12 1945, and that I last saw him alive on 3/12 1945
Immediate cause of death Respiratory Failure — Duration
Due to Mediastinal Shift
Due to Atelectasis of rt. lung; Pneumonitis of rt lung;
Other Conditions Multiple Lung Abscess. Bronchial Asthma
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: As Above
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Jerry Futterman M. D.
Address University Hosp Date signed 3/13

VS 150

X

C-26866

AB92529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 931

Registered No. C-26866

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 N. Green St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilson Black

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 20- 1888

8. AGE: Years	Months	Days	If less than one day
56	5	24	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Martin N. Black (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Ida Taylor (D)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/16/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Md
Location Baltimore Md

18 (a) Funeral director Tillmon Bros
(b) Address 1241 Lt Govt St

19 (a) MAR 15 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13- 1945, at 7.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12 1945, to 3-13- 1945, and that I last saw h im alive on 3-13- 1945.

Immediate cause of death cardiac failure — Duration ?

Due to hypertensive cardiovascular disease

Due to

Other Conditions Bronchiectasis & emphysema, rt. lung; bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. O'Barry M. D.
Address City Hosp. Date signed 3-19-45

G26867 — BALTIMORE CITY HEALTH DEPARTMENT — G26867

CERTIFICATE OF DEATH

83 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Emmanuel Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town [redacted] (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 W. Hamilton (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Graham.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27- 1906

8. AGE: Years 38 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Henry Briggs
13. Birthplace N. C.

MOTHER
14. Maiden Name Ida —
15. Birthplace N. C.

16 (a) Informant Ida Robinson
(b) Address 215 W. Hamilton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 18-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director James A Stayer
(b) Address 1442 W. Hill St

19 (a) MAR 15 1945 (Date filed by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13 1945 at 5:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/2 1945, to 3/13 1945, and that I last saw h[illegible] alive on 3/13 1945.

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. E. Clarence, M.D.
Address Emmanuel Hosp Date signed 3/13/45

X

G66868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

831 Registered No. G66868

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave & Dukeland St.
(c) Hospital or institution: West Balto Gen Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 N. Augusta Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Berta Shockley MISS BERTA ESTELLE SHOCKLEY

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 220-07-0196

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14th 1907

8. AGE: Years 37 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Bookbinder

11. Industry or business

FATHER
12. Name Micah D. Clayton Shockley
13. Birthplace Snow Hill, Md.

MOTHER
14. Maiden Name Ida M. West
15. Birthplace Snow Hill Md.

16 (a) Informant Mrs. Micah B. Shockley
(b) Address 834 S. Market St. Frederick, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) | 16 (day) | 45 (year)
(c) Cemetery or crematory Old School Baptist Church
Location Snow Hill, Md.

18 (a) Funeral director Jas. Weber & Son
(b) Address 2603 Edmondson Ave

19 MAR 15 1945 (b) [illegible] Williams M.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1945, at 11:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27/45 19 to 3/13/45 19, and that I last saw h[illegible] alive on 3/12/45 19.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cerebral Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James A. Dunbar M. D.
Address W. Balto Gen Hospital Date signed 3/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G26869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

130

Registered No. G26869

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1357 Waltymyer St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1357 Waltymyer St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** James Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1898

8. AGE: Years	Months	Days	If less than one day: hr.	min.
46	7			

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name ?
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace Md.

16 (a) Informant Nellie Simpson Dorsey
(b) Address 1408 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director L. Halstead
(b) Address 918 Druid Hill Ave.

MAR 15 1945 (Date rec'd by registrar)

(b) Huntingtor Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 11, 1945 at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 7 1945, to Mar 11 1945, and that I last saw h-m alive on Mar 11 1945.

Immediate cause of death Acute Nephritis — Duration 4 months

Due to Uremia — Duration 3 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cuthbert Frey M.D.
Address 1928 Pa Ave Date signed 3/13/45

X

VS 150

G6687 ✓ G6687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 450 Oxford Ct.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 450 Oxford Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Brown (Spann)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1897

8. AGE: Years	Months	Days	If less than one day
47 48	9	4	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Machine Operator
11. Industry or business

FATHER
12. Name Morris Brown
13. Birthplace S.C.

MOTHER
14. Maiden Name Lillie Owens
15. Birthplace S.C.

16 (a) Informant Mary I. Brown
(b) Address 450 Oxford Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-45 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 DRuid Hill Ave.

19 MAR 15 1945 (Date received by local registrar) (b) Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION 50

20. DATE OF DEATH Mar. 11, 1945 at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1945 to 3/11 1945, and that I last saw him alive on 3/10 1945

Immediate cause of death Apoplexy — Duration 14 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Hawkins M.D.
Address 490 W. Biddle St. Date signed 3/13/45

X

871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. G26871

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution:
Garrison Nursing Home 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2125 Mt. Holly St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: LYDIA M. BLACKMAN

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Enoch B. Blackman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/30/1860

8. AGE: Years 85 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Pleasantville, N. J.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jesse S. Reed
13. Birthplace Pleasantville, N. J.

MOTHER
14. Maiden Name Harriett Frambes
15. Birthplace Pleasantville, N. J.

16 (a) Informant Mr. Walter Reed
(b) Address 2125 Mt. Holly St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/16/45 (month) (day) (year)
(c) Cemetery or crematory
Location Pleasantville, N. J.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAR 15 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1945, at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 14 1944 to March 14 1945.
and that I last saw h[illegible] alive on March 12 1945

	Duration
Immediate cause of death Myocarditis	about 3 MO.
Due to advanced arterio-sclerosis	?
Due to	
Other Conditions Arterio Sclerosis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter S Tickner Dir.
Address 2220 Garrison Blvd Date signed March 15/45 M. D.

VS 150

G26872 ✓ G26872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 A Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 857 Woodward St
(c) Hospital or institution: University Hosp. 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 857 Woodward St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles M. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 9 1889

8. AGE:	Years	Months	Days	If less than one day
	55	3	4	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Grocer
11. Industry or business Self

FATHER
12. Name Chas M Davis Sr
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Louisa McCall
15. Birthplace Baltimore Md

16 (a) Informant Mrs Olivia Jones
(b) Address 857 Woodward St

17 (a) Burial (b) Date thereof Mar 16-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location

18 (a) Funeral director Chas P Powell
(b) Address 2427 Edmondson Ave

19 (a) MAR 15 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1945, at 11:55 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed March 13 1945

VS 151

Huntington Williams M.D.

AB-91656 G26873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1862 Registered No. G26873

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos- 27days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3001 Presbury St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George McCall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31-1873

8. AGE: Years 71 | Months 2 | Days 14 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George McCall
13. Birthplace ?

MOTHER 14. Maiden Name Sarah Mosley
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals-Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3707 W. North Ave

19 (a) (Date received by registrar) MAR 15 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1945, at 8.20AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-18 1945 to 3-14 1945, and that I last saw h... alive on 3-14 1945.

Immediate cause of death: Coronary occlusion — Duration: 4 days.

Due to:

Due to:

Other Conditions: fractured patella — 2 mos

(Include pregnancy within 3 months of death)

Date of operation 1-20-45

Major findings of operation: fractured patella.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following: 5/6 P.M.

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 1-17-45 at 7:15 P.M.

(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Public Alley (Specify type of place) While at work?

(e) Means of injury? Fell on ice.

23. Signature Houck E. Baltzer M. D.

Address Baltimore City Hosp. Date signed 3/14/45

To be approved by Medical Examiner Robert L. Graham M.D. X

G26874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G26874 Registered No. 13 12

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1919 W. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philip Rensch

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma H. Rensch
nee Koehnle 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1872

8. AGE: Years	Months	Days	If less than one day
73	1	2	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Bakery
11. Industry or business

FATHER
12. Name Henry Rensch
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Philip Rensch
(b) Address 1919 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 15/45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave. & Longwood St.

18 (a) Funeral director Harry H. Weitzfeld
(b) Address 4101 Edmondson Ave.

19 (a) MAR 15 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 19 45 6 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1945 to March 12 1945.
and that I last saw h alive on 19

Immediate cause of death	Duration
Chronic Myocarditis	
Due to Infirmity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Walter A Coe M. D.
Address 5 S Broadway Date signed 3-14-45

VS 150

G26875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G26875 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. This correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3510 Parkhaven Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1338 Hanover St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie D. Lynn

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Albert C. Lynn

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) April 1, 1891

8. AGE: Years	Months	Days	If less than one day
53	11	18	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Bernard Isrealson
13. Birthplace Germany

MOTHER
14. Maiden Name Don't Know
15. Birthplace Germany

16 (a) Informant Marvin D. Lynn (Son)
(b) Address 192 W. Meadow Rd. (Brooklandville)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 16-45 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Baltimore

18 (a) Funeral director A. Howard Evans
(b) Address 1400 St. Charles St. (Balto.)

19 (a) (Date rec'd by registrar) (b) Registrar

Mar Dec 15 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1945 at 6:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5/45 19__ to 3/13 1945.
and that I last saw h er alive on 3/13 1945

Immediate cause of death	Duration
Pulmonary Edema	1 day
Due to Metastatic carcinoma of liver	?
Due to Carcinoma of breast	2½ yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank Lemmon M. D.

Address 4004 Eutaw Place Date signed 3/14/45

G26876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

G26876 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2137 Harford Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2137 Harford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marilyn D. Stewart

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11-1943

8. AGE: Years 1 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Dale Stewart
13. Birthplace West. Vir.

MOTHER 14. Maiden Name Renetta Michael
15. Birthplace Balto.

16 (a) Informant Renetta Stewart
(b) Address 2137 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 16 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Balto.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans st

19 (a) MAR 15 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 14 1945; at 12-05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1943, to Mar 14 1945 and that I last saw h alive on Mch 14 1945.

Immediate cause of death Congenital Heart disease — Duration: life

Due to defective inter Ventricular Septum

Due to

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fritz J Kunzer M.D.
Address 700 Harford Rd Date signed 3/16/45

VS 150

G26877 — BALTIMORE CITY HEALTH DEPARTMENT — G26877

CERTIFICATE OF DEATH 182a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2534 West Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2534 West Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? N (Yes or No)
If yes, name country

3 (a) FULL NAME Rochelle Beth Phillips

3 (b) If veteran, name war X

3 (c) Social Security Account No. X

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. X

6 (b) Name of husband or wife

6 (c) If single, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9- 1945

8. AGE: Years | Months 2 | Days 63 | If less than one day hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Benj Phillips
13. Birthplace Russia

MOTHER
14. Maiden Name Nettie Yaffa
15. Birthplace Balto Md

16 (a) Informant Benj Phillips
(b) Address 2534 Cold Spring Lane

17 (a) Burial (b) Date thereof 3-15-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship
Location Balto & Conkling St

18 (a) Funeral director Jack Lewis, Inc
(b) Address 1436 E Balto St

19 (a) MAR 15 1945 (b)
(Registered by registrar)

Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1945, at 5:15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Died entangled in bedclothing

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/16 at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner.
Date signed 3/15/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3/13

Registered No. G26878

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton and Wilkens Ave

(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 925 N Luzerne Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Margaret Inglart

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-3187

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 29, 1896

8. AGE: Years	Months	Days	If less than one day
49		13	hr. min.

9. Birthplace Baltimore, Maryland. (Town, county, and state)

10. Usual Occupation Presser

11. Industry or business Kaylon, Ind.

FATHER

12. Name Phillip Inglart

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Getty Everett

15. Birthplace Baltimore, Md.

16 (a) Informant Rose Causey, sister

(b) Address 925 N. Luzerne Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/45 (month) (day) (year)

(c) Cemetery or ~~xxxxx~~ Baltimore

Location Baltimore, Md.

18 (a) Funeral director C. E. Schimunek

(b) Address 2601 E. Madison Street

19 (a) Filed by [illegible] (b) Address Huntingtown, Md.

MAR 15 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13 1945, at 6:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/11 1945, to 3/13 1945, and that I last saw her alive on 3/13 1945.

Immediate cause of death	Duration
Heart failure	
Due to Chronic glomerular nephritis & myocardial	
Due to degeneration	
Other Conditions Paraparesis & anuresis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William J. Bryan M. D.

Address St. Agnes Hosp Date signed 3/13/45

X

G26879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G26879 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 Homeland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward Reed Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	w	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/12/45

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Balto, Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name James Edward Reed
13. Birthplace Pa.

MOTHER 14. Maiden Name Grace Leona Dillinger
15. Birthplace Pa.

16 (a) Informant mother
(b) Address

17 (a) Interred (Burial, cremation, or removal) (b) Date thereof 3/16/45 (month) (day) (year)
(c) Cemetery or crematory Hill Grove
Location Connellsville Pa.

18 (a) Funeral director C. E. Schumpinel Sr.
(b) Address 2601 E. Madison St.

19 (a) (b)
(Date received) Registrar

MAR 19 1945
VS 15a

Huntington-Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14 1945 at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12 1945 to 3-14 1945 and that I last saw him alive on 3-14 1945

Immediate cause of death	Duration
Aspiration pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Consolidation of lungs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph S. Ardinger M.D.
Address 1213 Light St. Date signed 3-15-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Omit no item because you think it unimportant. Be sure to state the causes of death clearly and legibly. Please write the correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G26880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G26880 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bethlehem Steel Co Dispensary
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 437 N. Milton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kyriacos John Megas

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/20/1900

8. AGE: Years	Months	Days	If less than one day
45		23	hr. min.

9. Birthplace Imros Greece (Town, county, and state)
10. Usual Occupation Rigger
11. Industry or business Ship Building

FATHER
12. Name John Megas
13. Birthplace Imros, Greece

MOTHER
14. Maiden Name Marietta
15. Birthplace Imros, Greece

16 (a) Informant Mary Megas
(b) Address 437 N Milton Ave

17 (a) Burial (b) Date thereof 3/19/45 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory New National
Location Fairfield, Md.

18 (a) Funeral director J. J. Ruck
(b) Address 5305 Harford Ave

19 (a) (b)
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1945, at 8:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed March 15 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G26831

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Millersville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Nadolski

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:	Years	Months	Days	If less than one day
	1	6/28		hr. min.

9. Birthplace Maryland (Elvaton (Millersville) Md.)
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Francis Nadolski
13. Birthplace Elvaton - Millersville, Md. R.F.D.

MOTHER
14. Maiden Name Anna May Giles
15. Birthplace Elvaton Millersville Md. R.F.D.

16 (a) Informant Francis Nadolski
(b) Address Elvaton (Millersville Md) R.F.D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 16, 1945 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thomas W. Dugleson
(b) Address Glen Burnie, Md

19 (a) (b) Huntington Williams, M.D.
(Signature of registrar)
MAR 15 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1945 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased ~~from~~ on March 13 1945 to 19..., and that I last saw h.e.r alive on March 13 1945

Immediate cause of death	Duration
Respiratory Failure	2 days
Due to Acute laryngeo tracheal bronchitis	
Due to	
Other Conditions Lobular pneumonia upper right	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Millard F. Izzalond Jr.
Address University Hospital Date signed 3/14/45

106c

G26882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G26882 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City (If outside city or town limits write RURAL and give town)
(d) Street No. 905 N Calvert St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Michael J. McCRISAKEN ~~Hennessey~~

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 13 - 1886

8. AGE: Years 59 | Months 7 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace Indiana (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER 12. Name William McCRISAKEN ~~Hennessey~~

13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Morgue Records

(b) Address

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Mar 15-46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location

18 (a) Funeral director Charles P Powell

(b) Address 2427 Edmondson Ave

19 (a) MAR 15 1946 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/11 1946, at 9:20 M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury.....at.....M.

(b) Where did injury occur?.....

(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....

(d) Means of injury.....

23. Signature. P. R. Lubinski M.D. Medical Examiner.

Date signed 3/11/46

VS 151

100-24

X

G26883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 309

G26883 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: Univ. Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 Vienna Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucile Tillman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 / 16 / 1901

8. AGE: Years 43 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Charleston, N. C. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Mid Tillman
13. Birthplace N. C.

MOTHER 14. Maiden Name Maria Potter
15. Birthplace N. C.

16 (a) Informant Camille Tillman
(b) Address 5-48 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 / 16 / 45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. D. Kelson
(b) Address 1303 Pressman St

19 (a) (b) Registrar
(Date received by registrar) MAR 15 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12 1945, at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-10 1945, to 3-12 1945, and that I last saw her alive on 3-12 1945.

Immediate cause of death Cerebral hemorrhage — Duration

Due to Ruptured cerebral vein — over

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. M. Stroman M. D.
Address Univ. Hospital Date signed 3-13

X

G26884
469822.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

G26884
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raleigh Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	married

6 (b) Name of husband or wife Harriet
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 1890.

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Chauffeur.
11. Industry or business

FATHER
12. Name Joshua Smith
13. Birthplace Va

MOTHER
14. Maiden Name Lucinda Robinson
15. Birthplace Va.

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (b) Date thereof 3/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Nat'l
Location Md.

18 (a) Funeral director Geo. H. Nelson
(b) Address 1303 Pressman St.

19 (a) (Date rec'd) MAR 15 1945 (b) Washington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1945 at 7.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 2 1945 to March 14 1945.
That I last saw him alive on March 15 1945.

Immediate cause of death: Malignant neoplasm of stomach (?)
Marked emaciation

Duration
1 month (appr. from history)

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Manner of injury
23. Signature William J. Dixon
Address Johns Hopkins Hospital 3/14/45

626885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92c

626885

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 537 Mission Ct
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 537 Mission Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Jordan

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W

6 (b) Name of husband or wife Mary E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 24 1894

8. AGE: Years	Months	Days	If less than one day
50	6	21	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Samuel Jordan
13. Birthplace Balto. Md

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mary Buchanney
(b) Address 632 Baker St

17 (a) Burial (b) Date thereof 3/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Nat
Location Md.

18 (a) Funeral director Leo. H. Kelson
(b) Address 1303 Presstman St

19 (a) MAR 15 1945 (b) Huntington Williams
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1945, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rheumatic Endocarditis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Bratton M.D.
Medical Examiner.
Date signed March 15 1945

6886 X 1701 G26886

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D O A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Luthervill
(If outside city or town limits, write RURAL and give town)
(d) Street No. Seminary Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Leroy Gover, Jr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1942

8. AGE: Years	Months	Days	If less than one day
2	3	25 27	hr. min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Wm. LeRoy Gover
13. Birthplace Balto. Co. Md

MOTHER
14. Maiden Name Mildred A. Welke
15. Birthplace Baltimore, Md

16 (a) Informant Wm. L. Gover
(b) Address Lutherville, Md.

17 (a) Burial (b) Date thereof Mar. 18 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Poplar
Location Cockeysville, Md

18 (a) Funeral director Sander M. Sowers
(b) Address Govans, Md.

MAR 15 1945
(Date rec'd by registrar)
Hunting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1945, at 1 02 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Hus death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-15-45 at 12:40 P.M.
(b) Where did injury occur? Seminary Ave - Lutherville
(c) Did injury occur at home, on farm, industrial place, in public place? Private Property While at work? no
(d) Means of injury Auto Hood over child in driveway.

23. Signature Robert A. Graham M.D.
Medical Examiner.
Date signed March 15 1945

VS 151

G26887 BALTIMORE CITY HEALTH DEPARTMENT X G26887

CERTIFICATE OF DEATH 1318

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Treskow
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Louis Patrick Cantagnola

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1912

8. AGE: Years	Months	Days	If less than one day
32	3	9 10	10 hr. 30 min.

9. Birthplace Summit Hill, Pa.
(Town, county, and state)
10. Usual Occupation Priest
11. Industry or business

FATHER
12. Name Peter Cantagnola
13. Birthplace Italy

MOTHER
14. Maiden Name Finizia Fusco
15. Birthplace Italy

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof Mch. 17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Summit Hill
Location Summit Hill Pa
18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place (Successor to Williams & H...)
19 (c) MAR 15 1945 (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1945, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3 1945, to 3/15 1945, and that I last saw him alive on 3/15 1945.

Immediate cause of death: Toxic Psychosis — Duration: 12 days

Due to

Due to

Other Conditions: Chronic nephritis with an acute exacerbation — 12 days
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dunlap Bibby M. D.
Address 336 Northumberland Ave Date signed

84D

626888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 587

626886 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1638 N. Appleton St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley Schwartz
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2-9-30
8. AGE: Years 15 yrs. Months 1 Days 5 If less than one day hr. min.
9. Birthplace Maryland (City, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Harry Schwartz
13. Birthplace England

MOTHER 14. Maiden Name Mary Goldstein
15. Birthplace Maryland

16 (a) Informant Mother
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 16/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Sinai Cem. Co.
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave

19 (a) 3-16-1945 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1945 at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1945 to March 14 1945 and that I last saw h[illegible] alive on March 14 1945.

Immediate cause of death respiratory failure
Acute pulmonary edema
Due to Cardiac failure
Due to ? Pneumonia
? Acute rheumatic fever a
Other Conditions Pericarditis + pneumonia
Fröhlich's syndrome
(Include pregnancy within 3 months of death)

Duration
1 day
1 day

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham Cerecan M. D.
Address Johns Hopkins Hospital Date signed 3-14-45

VS 150

G26889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G26889

G26889

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2445 N. Charles St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2445 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISE S. ANDERSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George W. Anderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/15/1869

8. AGE: Years	Months	Days	If less than one day
76	2	0	hr. min.

9. Birthplace Savannah, Ga.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Herman Ruwe
13. Birthplace New York

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. William Keihe
(b) Address 2445 N. Charles St.

17 (a) Removal (b) Date thereof 3/16/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenwood Cem.
Location Brooklyn, N. Y.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)

MAR 15 1945 Registrar
Huntingtown, Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1945, at 3:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 2nd 1945, to Mar 15 1945; and that I last saw h. Ex. alive on Mar 14, 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	13 days
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George E. Cross M. D.
Address 28 W 20th St Date signed 3-15-45

X

G26890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G26890

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. Wells St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Eckenrode

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma Kelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 24 1872

8. AGE: Years	Months	Days	If less than one day
72	6	11	22 hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Dorsey Eckenrode
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Stoner
15. Birthplace Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 17/45 (month) (day) (year)
(c) Cemetery or crematory St. Johns Cem.
Location Westminster, Md.

18 (a) Funeral director J. E. Myers, Jr.
(b) Address Westminster, Md.

19 (a) MAR 16 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-15-1945, at 5-15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6-1945, to 3-15-1945, and that I last saw him alive on 3-15-1945.

Immediate cause of death	Duration
Broncho-pneumonia, due to exhaustion	
Due to Malignant neoplasm, site undetermined.	
Due to	
Other Conditions Metastases to liver and intestine	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ross L. McLean M.D.
Address J. H. H. Date signed 3-15-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

626891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 626891

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2042 Wallwork Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-4
(e) Length of stay in Baltimore (yrs., mos., or days) 24yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2042 Wallwork Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Yuldis Alta Bank

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Isadore Bank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1845

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel -
13. Birthplace Poland

MOTHER
14. Maiden Name Chia -
15. Birthplace Poland

16 (a) Informant Isadore Bank
(b) Address 2042 Wallwork Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1431 E. Balto St

19 MAR 16 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1945 at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1942 to March 15 1945, and that I last saw h... alive on ... 19...

Immediate cause of death Carcinoma of Breast — Duration 6 mos

Due to Metastasis of Ca to Lungs — 2 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Boral Gordon M. D.
Address 2201 W. North Ave Date signed 3-15-45

G26892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G26892

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 Gorsuch Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William H. Gay

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-01-6487

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband or~~ wife Nellie Irene Gay

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13th 1883

8. AGE: Years	Months	Days	If less than one day
61	5	2	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Service Man

11. Industry or business American Ice Co.

FATHER
12. Name Isaac Gay
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Nellie I. Gay
(b) Address 1504 Gorsuch Ave

17 (a) Burial (b) Date thereof 3/19/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 MAR 16 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15 19 45 at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Inquest on ~~Autopsy~~, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h-s death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. H. Zulbinski M.D.
Medical Examiner.
Date signed 3/16/45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G26893

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25
(c) Hospital or institution: South Baltimore Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Fairfield (If outside city or town limits, write R.F.D. and give town)
(d) Street No. 3419 Childs Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stella E. Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~or wife~~ Lee Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24th 1896

8. AGE: Years	Months	Days	If less than one day
48	4	2	hr. min.

9. Birthplace Green Co. Pa. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Austin R. Rutan
13. Birthplace Pa

MOTHER
14. Maiden Name Sarah E. Gonn
15. Birthplace Pa.

16 (a) Informant Lee Howard
(b) Address 3419 Childs Court

17 (a) Removal (b) Date thereof 3/16/45 (month) (day) (year)
(c) Cemetery ~~or Crematory~~ Highland
Location Cameron W. Va.

18 (a) Funeral director William Cook Inc
(b) Address 1417 St. Paul St.

19 (a) MAR 16 1945 (Date rec'd by registrar) by Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 19 45, at 2:50 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Les death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions Acute Pulmonary Edema, Arteriosclerosis Chronic Nephritis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walters M.D. Medical Examiner.
Date signed March 15, 1945

VS 151

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-66894 ✓ G-66894

AR-71841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs- 1mos-24-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Covington Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: James Irvin White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17- 1876

8. AGE: Years 68 | Months 8 | Days 28 | If less than one day hr. min. 27

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alec White
13. Birthplace Md.

MOTHER
14. Maiden Name Lucy Reely
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals-Records
(b) Address 4940 Eastern Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3- 17- 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Brooklyn Md.

18 (a) Funeral director James L. McCurdy
(b) Address 320 E. Fort Ave.

19 (a) MAR 16 1945 (Registered by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14- 1945, at 1.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14 1945, to 3-14- 1945, and that I last saw h im alive on 3-14- 1945.

Immediate cause of death	Duration
Chronic Lymphogenous Leukemia ?	3 years
Due to Basilic Neoplasm ?	
Due to	
Other Conditions Gen. Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospitals Date signed 3-16-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 626895

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1735 Covington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 Covington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Soloman P. Levingood

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Mary D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 7, 1887

8. AGE: Years 57 | Months 5 | Days 6. | If less than one day hr. min

9. Birthplace [redacted] Md
(Town, county, and state)

10. Usual Occupation Housemaid
11. Industry or business

FATHER
12. Name ? Soloman
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace Md

16 (a) Informant Family
(b) Address 1735 Covington St.

17 (a) Burial 8. (Burial, cremation, or removal) (b) Date thereof 3-17-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Jas. L. McCarthy
(b) Address 1300 E. Fort Ave.

19 (a) MAR 16 1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1945 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to March 13 1945 and that I last saw her alive on March 5 1945.

	Duration
Immediate cause of death Ulcerative Colitis	2 days
Due to Bronco Asphyxia	1 hr
Due to	
Other Conditions Hypertension	10 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hunt Williams M. D.
Address 8 E Randall Date signed 3-16-45

Hunting Williams, M.D.

626896 | BALTIMORE CITY HEALTH DEPARTMENT | 626896

CERTIFICATE OF DEATH

47a | Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1154 Sargeant St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1154 Sargeant St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry N. McKenna

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Clara Reathman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4, 1888

8. AGE: Years	Months	Days	If less than one day
56	5	9	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Commission Merchant.
11. Industry or business

FATHER
12. Name Harry McKenna
13. Birthplace Maryland

MOTHER
14. Maiden Name Cora Connelly
15. Birthplace Md

16 (a) Informant Mrs. Clara R. McKenna
(b) Address 1154 Sargeant St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/45 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Dorsey Md

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 E. Monument Ave.

19 (a) (Date received by Registrar) MAR 16 1945 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1945 at 3:25 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/24 1945 to 3/13 1945. and that I last saw h. alive on 3/11 1945.

Immediate cause of death Coronoma of Larynx — Duration Chronic

Due to —

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec. 1944

Major findings of operation: Ca of Larynx

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury

23. Signature Huntington Williams M.D.

Address 1310 Eutaw Pl. Date signed 3/15/45

X

G26897 ✓ G26897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 529 S. Paca
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 529 S. Paca (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda J. Jackson

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/17/1882

8. AGE: Years 63 | Months — | Days 24 | If less than one day hr. 7 min.

9. Birthplace Charles Co Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Patrick Turner
13. Birthplace Md

MOTHER
14. Maiden Name Caroline Marshall
15. Birthplace Md

16 (a) Informant Josephine Turner
(b) Address 529 S. Paca St

17 (a) Burial (b) Date thereof 3/18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Balto Co Md

18 (a) Funeral director Isaac L. Brown & Son
(b) Address 25 N Montgomery St

19 (a) Filed [illegible] (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13/1945 at 7 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10/1944 to 3/13/1945 and that I last saw h alive on 3/12/1945

Immediate cause of death	Duration
Pulmonary Edema	
Hypertensive Cardio Vascular Renal Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Howells M. D.
Address 601 N Carrollton Ave Date signed 3/16/45

626898

BALTIMORE CITY HEALTH DEPARTMENT ✓ 626898

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 932 Warren
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 932 Warren (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wesley Colby
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex male | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. d
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 15, 1872
8. AGE: Years 73 | Months - | Days 26 | If less than one day hr. min.
9. Birthplace Calvert Co Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Caroline ?
15. Birthplace Md

16 (a) Informant Bertha Stanard
(b) Address 932 Warren St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City
18 (a) Funeral director Israel L Brown Co
(b) Address 101 W Montgomery St
19 (a) MAR 16 1945 (Date rec'd by registrar) (b) Registrar's signature William

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13/ 1945 at 10 15 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 1/18 1945 to 3/13 1945
and that I last saw h alive on 3/10 1945.

	Duration
Immediate cause of death Chronic Myocarditis	
Due to Chronic Nephritis	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. F. Boyle M.D.
Address 601 N. Carrollton Ave. Date signed 3/15/45

VS 150

G26899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

G26899 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-0-1A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 W. Fayette Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** William [redacted] Hofmann.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27 - 1890

8. AGE: Years 54 5-3 | Months 7 6 | Days 18 17 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Merchant.

11. Industry or business Self.

FATHER 12. Name George Hofmann

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Emma White

15. Birthplace Baltimore Md

16 (a) Informant George Hofmann

(b) Address 150 Susquehanna Ave. Towson Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park.

Location

18 (a) Funeral director Charles P Powell

(b) Address 1517 Edmondson Ave

19 (a) (Name of informant) (b) Huntington Williams, M.D.

MAR 16 1945

correct age is especially important. Physicians: please write the

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 - 13 - 1945, at 1 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Diffuse Purulent Peritonitis

Due to Perforated Gastric Ulcer

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 3-13-45

G26900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

✓ G26900 Registered No.

PLEASE WRITE PLAINLY, with unfading ink. Physicians: please write the causes of death clearly and legibly. Give full name of street and number. Do not use abbreviations. Do not omit any information requested. If unknown, say so. Do not leave any space blank. Be sure to answer all questions. Be sure to write correct age in every case. Be sure to write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1031 Edmondson ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 38 Winters ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John Henry Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Genevieve Pettyman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1872

8. AGE: Years	Months	Days	If less than one day
72	9	8	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Odd Jobs

FATHER
12. Name Samuel Thomas Dorsey
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Norris
15. Birthplace Md.

16 (a) Informant Genevieve Dorsey
(b) Address 38 Winters ave. Catonsville

17 (a) Burial (b) Date thereof Mar. 16, 194
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Lukes Cem.
Location Catonsville, Md.

18 (a) Funeral director C. Harry Ward
(b) Address Catonsville, Md.

19 (a) MAR 16 1945 (M) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1945, at 9:25 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Mar. 5, 1945 to Mar. 13, 1945, and that I last saw him alive on March 5, 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 5 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 3/13/45

VS 8

G26901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 20

G26901 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2905 Fait Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2905 Fait Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Earl Neal

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-7569

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Hilda H. Porsinger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1906

8. AGE: Years	Months	Days	If less than one day
38	11	3	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Office Work
11. Industry or business Conn. Can Co.

FATHER
12. Name John E.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Friedenwald
15. Birthplace Baltimore Md.

16 (a) Informant Wife
(b) Address 2905 Fait Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway.

19 (a) (b) Registrar

MAR 16 1945

VS 126

Arlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1945 at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to March 13 1945, and that I last saw him alive on March 13 1945.

Immediate cause of death: Renal Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene Zeller, M.D.
Address 2739 Eastern Ave Date signed 3/13/45 (M. D.)

X

G26902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57E

G26902 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2214 Annapolis Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thelma M. Roman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Leroy Roman

6 (c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): 12-29-05

8. AGE: Years: 39 | Months: 2 | Days: 28 | If less than one day: hr. min.

9. Birthplace: Maryland - Balto (Town, county, and state)

10. Usual Occupation: House Wife

11. Industry or business

FATHER
12. Name: William T. Duvall
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mary M. [illegible]
15. Birthplace: Maryland

16 (a) Informant: Husband
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 17, 1945 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: City

18 (a) Funeral director: Mrs. Mrs. John W. Teufel & Son
(b) Address: 804-805 Fayette St.

19 (a) MAR 16 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14 1945, at 2:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1945, to March 14 1945, and that I last saw her alive on March 14 1945.

Immediate cause of death: (a) Hemorrhage
? Pituitary tumor

Due to:

Due to:

Other Conditions: Ventricular

(Include pregnancy within 3 months of death)

Date of operation: 3/13/45

Major findings of operation: Basedow
carcinoma of pituitary gland.

of autopsy:

Duration: (a) 2 hrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Lew W. Chambers
Address: Johns Hopkins Hosp. Date signed: 3/14/45

G26903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30D

Registered No. G26903

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 Woodlawn Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Warrington Apts 3908 N. Charles (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Runyon Shaw

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 26 1873

8. AGE: Years	Months	Days	If less than one day
71	11	17	20 hr. min.

9. Birthplace Cumberland Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James L. Shaw
13. Birthplace New Jersey

MOTHER
14. Maiden Name Annie E. Percy
15. Birthplace Md

16 (a) Informant Mrs. Howard Reese Duncan
(b) Address 100 Woodlawn Road

17 (a) London (b) Date thereof Mar 17 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London
Location Baltimore

18 (a) Funeral director Henry W. Jenkins & Sons Co
(b) Address MAR 17 1945 Paul L. Packard Huntington Williams

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 21 1944, to Mar. 15 1945, and that I last saw h[illegible] alive on Mar. 3, 1945

Immediate cause of death	Duration
Coronary Occlusion	
Due to Hypertensive Cardiac Disease	
Due to Dissecting Aneurism of the Aorta?	2½ Mos.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation No —
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
Signature M. Gibson Porter M. D.
Address 4622 Roland Ave Date signed 3/15/45

626904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

626904 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 W. 20th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 5
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 W. 20th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James D. Price

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9 | 1897

8. AGE: Years 47 48 | Months .6. | Days 4 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name William H. Price

13. Birthplace Va

MOTHER 14. Maiden Name Emma Price

15. Birthplace Va

16 (a) Informant Mary Read

(b) Address 914 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A & C Co

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E Preston St

19 (a) (Date rec'd by registrar) (b) Huntington Matthews, M.D. (Local Reg.)

MAR 16 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1945 at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 5 1945 to Mar 13 1945, and that I last saw h. alive on Mar. 13 1945.

Immediate cause of death: Cerebral Haemmorhage — Duration: 7 da.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis A. Johnson M. D.

Address 2329 Garrett Pl Date signed Mar. 16 1945

X

626903

BALTIMORE CITY HEALTH DEPARTMENT JAN 626903

CERTIFICATE OF DEATH

Registered No. 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 949 Bennett Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 949 Bennett Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward Hopps

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/23/1903

8. AGE: Years	Months	Days	If less than one day
41 42	7	15	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Grant Hopps
13. Birthplace Maryland

MOTHER
14. Maiden Name Irene Wheeler
15. Birthplace Maryland

16 (a) Informant Mrs Francis Hamilton
(b) Address 1616 E. Hoffman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County

18 (a) Funeral director Layner Sanders
(b) Address 1412 E. Preston Street

19 (a) (Date received by registrar) MAR 16 1945 (b) Huntington Williams, Registrar

VS 18

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1945, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1945 to March 12 1945, and that I last saw h alive on 19

Immediate cause of death: Bronchopneumonia — Duration 1 wk.
Due to Ch. Bronchitis — (?)
Due to Hypertension Cardiac Disease & Nephritis — (?)
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

M. Signature Jos. D. Julian Jr. M. D.
Address 511 N. Schroeder St Date signed

X

G26906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G26906 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 609 N. Potomac St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 N. Potomac St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Fertitta Glorioso

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Rosario Glorioso
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1865

8. AGE: Years	Months	Days	If less than one day
79	4	5	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Home Maker
11. Industry or business — —

FATHER
12. Name Antonio Fertitta
13. Birthplace Italy

MOTHER
14. Maiden Name Maria Deglia
15. Birthplace Italy

16 (a) Informant Mrs. Anna Bruno
(b) Address 609 N. Potomac

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 17-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank V. Pipitone
(b) Address 241 E. Baltimore St.

19 (a) (Date received by registrar) (b) Huntington & Williams, Mortuary

MAR 16 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1945, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 8 1945 to Mar 15 1945 and that I last saw her alive on Mar. 15 1945

Immediate cause of death	Duration
Papitral Thrombosis	
Due to Gas Gangrene	
Due to Senile Arteriosclerosis ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Valentine M.D.
Address 1732 N. Broadway Date signed 3/16/45

G26907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G26907 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1726 Fleet Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 ~~7~~ 3
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 Fleet Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME CATHERINE FABISZAK

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 15, 1871

8. AGE: Years	Months	Days	If less than one day
73	10	29	hr. min.

9. Birthplace Gozdowo, Poland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Adalbert Zubrowski
13. Birthplace Gozdowo, Poland

MOTHER
14. Maiden Name Agatha Kmiecik
15. Birthplace Gozdowo, Poland

16 (a) Informant Miss Mamie Fabiszak
(b) Address 1726 Fleet Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M. J. Sadowski Sons
(b) Address 1808 Eastern Avenue.

19 (a) Registrar Huntington Williams, M.D.

MAR 16 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1945, at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 19 44, to March 14, 1945; and that I last saw h[illegible] alive on March 13 1945.

Immediate cause of death: Lobular Bronchial Pneumonia — Duration 2 days
Due to:
Due to:
Other Conditions: Cerebral Apoplexy — Duration 2 mos.
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —
23. Signature John J. Triage M. D.
Address 2[illegible] Eastern Ave Date signed 3/16/45

G26908 ME.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G26908

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2829 Presstman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2829 Presstman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE D. LADD

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elsie J. Ladd (Loeser)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1872

8. AGE: Years	Months	Days	If less than one day
72	11	11	hr. min.

9. Birthplace Boston, Mass.
(Town, county, and state)
10. Usual Occupation National Park Service,
11. Industry or business Wash., D. C.

FATHER
12. Name Dexter Ladd
13. Birthplace Maine

MOTHER
14. Maiden Name Mary ?
15. Birthplace Mass:

16 (a) Informant Mrs. Elsie J. Ladd
(b) Address 2829 Presstman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address 1 E. Balto., Md. (Assisting for Williams, M.D.)

MAR 16 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1945, at 8:15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14 1945, to 3-15 1945, and that I last saw h[illegible] alive on 3-15 1945.

Immediate cause of death	Duration
Coronary Thrombosis	11 hours
Due to Arteriosclerosis	3 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon Coleman M. D.
Address 1201 Pydes Mont St. Date signed 3-15-45

Approved by Howard J. Clement M.D.

VS 150

• PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1340

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Andover Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Americus A. Pavese

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Lauretta. Pavese

6 (c) If alive, give age . years

7. Birth date of deceased (mo., day, yr.) 5-28-1901

8. AGE: Years 43 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Newark New Jersey. (Town, county, and state)

10. Usual Occupation Owner - Restaurant.

11. Industry or business Self

FATHER
12. Name Generoso. Pavese
13. Birthplace Italy.

MOTHER
14. Maiden Name Lucy Delloso
15. Birthplace Italy.

16 (a) Informant Mrs. Lauretta Pavese
(b) Address 1100 Andover Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tiefenthaler & Sons
(b) Address Cathedral & Md.

19 (a) MAR 16 1945 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1945; at 1:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1945, to 3/15 1945, and that I last saw him alive on 3/15 1945.

Immediate cause of death: Cardiac respiratory failure — Duration: 8 hrs.
Due to: multiple pulmonary Emboli. — over
Due to: sequellae to Sepsis - 4 days ap.
Other Conditions: Gastritis -
(Include pregnancy within 3 months of death)

Date of operation March 10
Major findings of operation: Essentially normal Cystoscopic Examination
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Patrick C. Phelan M. D.
Address Mercy Hospital Date signed 3/16/45

VS 150

G26910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G26910

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1515 Ellamont St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 Ellamont St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN WILLIAM STEPHENS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1884

8. AGE: Years	Months	Days	If less than one day
60	9	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John H. Stephens
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Caroline Barker
15. Birthplace Carroll Co., Md.

16 (a) Informant Mrs. Nellie Jones
(b) Address 1515 N. Ellamont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/16/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem. Balto., Md.
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 16 1945 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1945, at 7:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1943 to March 13 1945, and that I last saw him alive on March 12 1945

Immediate cause of death	Duration
Chronic Cardio Vascular Disease	5 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ernest W. Rahn
Address 173 - Pap Gr Dr Date signed 3/15/45

VS 150

626911

626911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2824 Raynor Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2824 Raynor Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret L. Claggett

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14/45, at 10:50 P.M.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Herbert C. Claggett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/27/1881

8. AGE: Years 63 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Henry Hamp
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Elizabeth Jacobs
15. Birthplace Balto. Md

16 (a) Informant Earl C. Claggett
(b) Address 2824 Raynor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 17 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director Maggie Cook Lyfer
(b) Address 1600 W. North Ave

19 (a) [illegible] (Date received by Registrar) (b) Interring for Hitting Mort.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive Cardio-vascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.
Date signed 3/16/45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E ✓

Registered No. 6912

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3732 Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3732 Falls Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie O'Shea

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 4. 1864

8. AGE: Years	Months	Days	If less than one day
80	5	9 10	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housework - Keeping

11. Industry or business

FATHER 12. Name Johns Thomas
13. Birthplace Maryland.

MOTHER 14. Maiden Name Martha Akers
15. Birthplace Maryland.

16 (a) Informant Melissa Bowers
(b) Address 3732 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/45 (month) (day) (year)
(c) Cemetery or crematory Asbury M.E. Cemetery
Location Reisterstown, Md.

18 (a) Funeral director Howard H. Blight Jr.
(b) Address 4914 Belair Road

19 (a) MAR 16 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14th 1945, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1945 to March 14th 1945; and that I last saw her alive on March 14th 1945:

Immediate cause of death Virus pneumonia — Duration 48 hr.

Due to Myocarditis — 18 Mo.

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No.
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. A. Zeller M. D.
Address 3611 Falls Rd. Date signed 3/14/45

VS 150

X

626913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

626913
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1611 Cliftview Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Cliftview Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Schwartz

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John C. Schwartz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1874

8. AGE: Years	Months	Days	If less than one day
70	4	18	hr. min.

9. Birthplace Franklin Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name James Howearth
13. Birthplace England

MOTHER
14. Maiden Name Elizabeth Morrow
15. Birthplace Canada

16 (a) Informant Mr. John C. Schwartz
(b) Address 1611 Cliftview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 19/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) MAR 16 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14/45 19 at 4:10 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1945 to Mar 14 1945 and that I last saw h e alive on Mch 13 1945.

Immediate cause of death	Duration
Diabetes Mellitus	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jacob Fisher M. D.
Address 843 N. Eutaw St. Date signed 3/15/45

X

G26914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G26914

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 325 W 28th St
(c) Hospital or institution: 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 325 W 28th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	W

6 (b) Name of husband or wife Julia Anne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1847

8. AGE: Years	Months	Days	If less than one day
98			hr. min.

9. Birthplace St Mary's Co. Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Unobtainable
13. Birthplace

MOTHER
14. Maiden Name Anna Buckler
15. Birthplace Md

16 (a) Informant Meyburn Thomas
(b) Address 325 W 28th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/45 (month) (day) (year)
(c) Cemetery or crematory Ft Peles
Location Md

18 (a) Funeral director Geo. H. Kelso
(b) Address 303 Freshman St

MAR 16 1945
(Date rec'd by registrar) Huntington Williams

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1945 at 5th P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 6, 1945 to March 15 1945 and that I last saw h[illegible] alive on March 13, 1945.

Immediate cause of death	Duration
Hypertension Cardio Vascular Disease	2 yrs.
Due to	
Due to	
Other Conditions Bronchial Pneumonia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mamie Adams M. D.
Address 312 E 23rd St Date signed 3-16-45

626915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

64

Registered No. 626915

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 W. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Audrey O. Forbes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1944

8. AGE: Years	Months	Days	If less than one day
—	2	17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Archie Forbes
13. Birthplace Va.

MOTHER
14. Maiden Name Irene Jennings
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Maude Jennings
(b) Address 1126 W. Franklin St

17 (a) Burial (b) Date thereof Mar. 16, '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 325 Pennsylvania Ave Huntingtown Williamsport, Md.

19 (a) MAR 16 1945
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION 36

20. DATE OF DEATH March 12 1945, at 7 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Enlargement of Thymus

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Graham M.D.
Medical Examiner.
Date signed March 14 1945

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 832

Registered No. 626916

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 438 W. Conway St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Gunther

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	married

6 (b) Name of husband or wife Annie Gunther
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25 - 1889

8. AGE: Years	Months	Days	If less than one day
55	2	20	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Sole Gunther
13. Birthplace Va.

MOTHER
14. Maiden Name Aristis ?
15. Birthplace Va.

16 (a) Informant Mrs. Annie Gunther
(b) Address 726 N. Stockton St

17 (a) Burial (b) Date thereof Mar. '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 MAR 16 1945 Huntington Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14-45, at 11:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage
Post Mortem

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature Howard J. Maldeis M.D.
Medical Examiner.
Date signed 3-14-45

VS 151

626917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. 626917

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2014 Booth St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2014 Booth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE H. RILEY SR

3 (b) If veteran, name war None | 3 (c) Social Security Account No.

4 Sex Male | 5 Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Annie E. Riley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? - 187?

8. AGE: Years 73 | Months ? | Days ? | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None
11. Industry or business Unknown

FATHER 12. Name ✓
13. Birthplace

MOTHER 14. Maiden Name ✓
15. Birthplace

16 (a) Informant George H. Riley Jr
(b) Address 1919 Riggs Ave

17 (a) Burial (b) Date thereof Mar 19-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balt C & B M Walter City

18 (a) Funeral director Pratt & Strieker
(b) Address

19 (a) (b) Huntington Williams, M.D.

MAR 16 1945

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MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1945 at 11 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26th 1945 to March 15 1945
and that I last saw him alive on March 14 1945.

Immediate cause of death Uraemia — Duration 2 days

Due to Chr. Nephritis — Duration 3 years

Due to Chr. Nephritis — Duration 3 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. M. McDermott M. D.
Address 1136 Park Ave Date signed 3/15/45

G26918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 E. Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 Talbott St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Valeria Burkhardt

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband ~~or wife~~ Jos. J. Burkhardt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28-1864

8. AGE: Years 80 81 | Months — 10 | Days - 17 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jos. Lempke
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Anna Burkhardt
(b) Address 20 Talbott St (25)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) 19 (day) 45 (year)
(c) Cemetery or crematory Cemetery
Location New Cathedral Cem.

18 (a) Funeral director Milton Schilling
(b) Address 3914 S. Hanover St

19 (a) (Date received by Local Registrar) (b) Registrar

MAR 16 1945
File No.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1945 at 9.25 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from March 7 1945 to March 15 1945, and that I last saw him alive on March 14 1945

Immediate cause of death: Fracture of Neck of Femur (a) Duration
Fracture of Femur - Left (b)
Due to Stroke.
Due to
Other Conditions Myocarditis + Bronchial Pneumonia
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident.
(b) Date of occurrence March 6, 1945 at P. M
(c) Where did injury occur? 20 Talbott St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Slipped & fell from Step

23. Signature Milton Schilling
Address 1337 S. Charles St Date signed 3/16/45

Huntington Williams M.D. Approved by Howard J. Andrews, M.D.

G26919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G26919 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 409 E. Fort Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 E. Fort Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William T. Spencer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Mary E. Spencer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20-1874

8. AGE: Years 70 | Months 6 | Days 22½ | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Extra Work

11. Industry or business

FATHER
12. Name John Spencer
13. Birthplace England

MOTHER
14. Maiden Name Josephine Murry
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Mary E. Spencer
(b) Address 409 E. Fort Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Flanagan
(b) Address 1426 Light St.

19 (a) MAR 16 1945 (Date received by Registrar) Registrar Hunter for Baltimore, Md.

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MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1945 to March 17 1945, and that I last saw h[illegible] alive on March 14 1945.

Immediate cause of death	Duration
Acute Dilatation of Heart.	1 hr.
Due to — Chronic Mitral Regurgitation	2 yrs
Due to — Arteriosclerosis	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Wheeler MD M. D.
Address 1279 Bolton St Date signed 3/16/45

X

G-26920

HEALTH DEPARTMENT—CITY OF BALTIMORE

G26920

159

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4113 Rondo Ct St., 5 Ward)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Baby Boy Nancy Y

(a) Residence: No. 4113 Rondo Ct St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Wh.	[redacted]

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Mar. 15, 1945

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or 15 min.
15 Minutes			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Brooklyn - Md

FATHER

13. NAME Elmer Lawrence Nancy

14. BIRTHPLACE (city or town) (State or country) Hughart W. Va

MOTHER

15. MAIDEN NAME Virginia Mae Lyons

16. BIRTHPLACE (city or town) (State or country) Hughart W Va

17. INFORMANT

(Address)

18. BURIAL, CREMATION, OR REMOVAL

Place [redacted] MAR 16 1945 19

19. UNDERTAKER [redacted]

(Address)

FILED MAR 16 1945 Huntington Williams, M.D.
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 3/15/45, 19

22. I HEREBY CERTIFY, That I attended deceased from Mar. 15 1945 to Mar. 15 1945

I last saw him alive on Mar. 15 1945 Death is said to have occurred on the date stated above, at 12 45 m.

The principal cause of death and related causes of importance were as follows:

Prematurity Cause unknown — Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

..... If so, specify .....

(Signed) Samuel Ramos, M. D.

(Address) 203 Patapsco Ave.

2585

X

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement OCCUPATION is very important. See instructions on back of certificate.

G26921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160C

Registered No. G26921

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Baltimore
(c) Hospital or institution: General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Emerson Ellsworth (Baby Boy)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day hr. 15 min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Hollis Franklin Ellsworth
13. Birthplace Appalachia Va.

MOTHER
14. Maiden Name Bonnie Jean Flint
15. Birthplace Burnsville, W. Va.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAR 16 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAR 16 1945 (Date filed by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15/45 at 5:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1945 to 3/15 1945, and that I last saw him alive on 3/15 1945.

Immediate cause of death 5hrs Prematurity Separation of Placenta
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward C. Day M.D.
Address West Balto Gen Hosp Date signed 3/16

2584

VS 150

6269-42

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. 6269-42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1/2 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and name of county)
(d) Street No. 1619 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Holmes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race B

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day 6 hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Kentuice Holmes
15. Birthplace Md.

16 (a) Informant Hosp Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL MAR 16 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 16 1945 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10-45 at 4P M

21. I certify that death occurred on the date above stated, that I attended deceased from 3-10 1945 to 19
and that I last saw h alive on 19

Immediate cause of death Bronchopneumonia

Due to Resp. Failure

Due to Due to prem

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature J. Curd Stark M. D.
Address Mercy Hosp (Date signed) 3-10-45

VS 150

2583

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

626923 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1305 Homewood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 N. Collington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida M. Warmsley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Pemberton Warmsley

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 6 - 1874

8. AGE: Years 70 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace Harford Co. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joshua W. Holland
13. Birthplace Harford Co. Md.

MOTHER 14. Maiden Name Anna M. Pyle
15. Birthplace Harford Co. Md.

16 (a) Informant Mrs. Alice Shea
(b) Address 1305 Homewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore Md.

18 (a) Funeral director Flynn & Flannery
(b) Address 1476 Light St.

19 (a) MAR 16 1945 (Date received by registrar)
Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1945 at 10 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944, to March 14 1945 and that I last saw h[e]r alive on March 13 1945

Immediate cause of death: Acute cardiac Failure. | Duration: few hours.
Due to: Arteriosclerotic Heart Disease | 5 yrs.
Due to: Cancer of Bowel (descending portion) | 2 yrs
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M. D.
Address 2443 E Monument St Date signed 3/15/45

6269 24

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 6269 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 209 N Lakewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 209 N Lakewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Jacob Kaszak (Kaspar)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Josephine Kaszak

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1865

8. AGE: Years 79 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Mt Clare B & O shops

11. Industry or business

FATHER
12. Name Don't Know
13. Birthplace " "

MOTHER
14. Maiden Name Mary Silver
15. Birthplace Poland

16 (a) Informant Mrs Mollie Blanchfield
(b) Address 209 N Lakewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 17/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location

18 (a) Funeral director Allison Funeral Home
(b) Address 2004 E Oliver St

19 (a) (Date received by registrar) MAR 15 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1945 at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 11 1945 to March 14 1945 and that I last saw h alive on March 14 1945

Immediate cause of death: (a) Acute Cerebral Apoplexy — Duration 3 days
Due to (b) Cerebral Arteriosclerosis & Hypertension
Due to (c)
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 200 E Fayette St Date signed 3/14/45

G26925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

G26925 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Heights ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3514 Clifton avenue
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH R. BUSSEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
-----	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Married

6 (b) Name of husband or wife Thomas E. Bussey
6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) May 24, 1870

8. AGE: Years	Months	Days	If less than one day hr.	min.
74	9	21		

9. Birthplace Huntville Alabama
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Thomas Reilly
13. Birthplace Ireland

MOTHER
14. Maiden Name Emma Ozaline Vasin
15. Birthplace Charleston, S.C.

16 (a) Informant Col. John E. Carroll
(b) Address 3514 Clifton avenue

17 (a) Burial (b) Date thereof 3/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Joseph's
Location Emmitsburg, Maryland

18 (a) Funeral director Chas J. Eggan, Son, Inc
(b) Address 118 N. Mt. Royal Ave.

19 (a) (b) Huntington Williams
(Date rec'd by registrar) (Signature)

MAR 16 1945

vs 1

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1945, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1935 to Mch 15 1945
and that I last saw h Le alive on Mch 13 1945

Immediate cause of death	Duration
Exhaustion	
Due to Pyelitis + Nephritis Sub acute	
Due to Bladder infection and ascending infection	8 wks
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature
Address 115 E Eager St Balto Date signed 3/16/45
M. D.

626926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

626926 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Ave.
(c) Hospital or institution:
Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 30 N Fulton Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ellen Brady

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~

6 (b) Name of husband or wife Thos. E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: ~~Years~~ 88 | Months | Days | If less than one day hr. min.

9. Birthplace ~~Ireland~~ Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Morris Jay

13. Birthplace Ireland

MOTHER 14. Maiden Name Ellen Griffin

15. Birthplace Ireland

16 (a) Informant Forget Next of Kin

(b) Address

17 (a) Burial (b) Date thereof 3-14-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore Md

18 (a) Funeral director Joyce & Tarleton

(b) Address Fulton & Lafayette

19 (a) 1945 Huntington Williams M.D.
(Issued by registrar) Registrar

R 16

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 1945, at 4:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1944, to 3/16 1945, and that I last saw h[illegible] alive on 3/16 1945.

Immediate cause of death	Duration
Heart failure	
Due to Chronic myocardial degeneration	
Due to	
Other Conditions Marked arthritis deformans (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Bryan M.D.

Address 1000 Cathedral Date signed 3/16/45

626927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

626927 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) huge

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3641 Greenmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Agnes Hewern

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widow

6 (b) Name of husband or wife Charles Hewern

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20 1878.

8. AGE: Years	Months	Days	If less than one day
66	5	24	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Hughes.
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Morris Nagle
15. Birthplace Md.

16 (a) Informant Helen M. Rumble
(b) Address 3641 Greenmount Ave

17 (a) Burial (b) Date thereof March 17-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director J. E. Moran
(b) Address 3000 E. Baltimore St.

19 (a) MAR 16 1945 Williams Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 14, 1945, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 7 1945 to Mar 14 1945, and that I last saw h alive on Mar 14 1945.

Immediate cause of death	Duration
Coronary Thrombosis	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. W. Hemingway Jr. M. D.
Address 32 S. Greenmount Ave Date signed 3/14/45

Huntington

VS 150

G26928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G26928 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1122 S. Highland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 S. Highland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Mary Miller

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henry Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 12/23/65

8. AGE: Years 79 | Months 2 | Days 20 23 | If less than one day hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Housewife
11. Industry or business: at home

FATHER
12. Name: Paul Stern
13. Birthplace: Balto., Md

MOTHER
14. Maiden Name: Anna ?
15. Birthplace: Balto., Md

16 (a) Informant: ROSE ARNOLD (DAUGHTER)
(b) Address: 1122 S.HIGHLAND AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/45 (month) (day) (year)
(c) Cemetery or crematory: First United Evang
Location: O'Donnell Street

18 (a) Funeral director: Lilly + Geiss Inc.
(b) Address: 405 S. Wolfe Street

19 (a) MAR 16 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH: March 15, 1945 at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1943, to Mar 15 1945, and that I last saw h[illegible] alive on Mar 14 1945

Immediate cause of death: Cerebral Thrombosis
Myocarditis

	Duration
Due to	1944
	1943
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: A. J. Rodman M. D.
Address 3505 Date signed 3/16/45

X

G26929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G26929

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 W 1st Royal (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jane Ann Domke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-25-45

8. AGE: Years | Months | Days 1 6 weeks | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry A. Domke

13. Birthplace Fort Worth, D.C.

MOTHER 14. Maiden Name Ida Bailey

15. Birthplace Penna

16 (a) Informant Records. JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-45 (month) (day) (year)

(c) Cemetery or crematory Prospect Hill

Location Towson, Md.

18 (a) Funeral director STEWART & MOWEN COMPANY (W. F. WOODEN SUC.)

(b) Address 100 W. NORTH AVENUE Huntington Williams, Mgr.

MAR 16 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1945 at 2:[illegible] P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 11 1945 to Mar 15 1945 and that I last saw her alive on Mar 15 1945

Immediate cause of death	Duration
Congenital heart disease — trauma	
Due to arteriosus c malposition of stomach,	
Due to	
Other Conditions spleen, large intestine. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: not complete or reported

PHYSICIAN Underline the cause to which death should be charged statis-

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John R. Burningham. M. D.

Address JHH Date signed 3-16

VS 150

626930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 27a

Registered No. 6269 0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6131 Cornwall Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John William Bennett.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-15-40

8. AGE: Years	Months	Days	If less than one day
4	4	0	hr. min.

9. Birthplace TAMAQUA—Penn.
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name Walter Bennett.
13. Birthplace Tamaqua, Penn.

MOTHER
14. Maiden Name Louise C. Womat.
15. Birthplace Penn.

16 (a) Informant Record.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Odd Fellows Cem.
Location Tamaqua Penna

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

19 (a) MAR 16 1945 (b) Huntington Williams, M.D.
(Date filed by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March - 15 1945 at 11:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March-15 1945 to March-15 1945 and that I last saw him alive on March-15 1945.

Immediate cause of death	Duration
Peripheral circulatory collapse	6 hrs
Due to Bacillary dysentery	24 hrs
Due to	
Other Conditions Apalestasis, partial	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Curtis W. Lukemire

Address Johns Hopkins Hospital Date signed 3/18/45
M. D.
Baltimore Md X

G26931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

G26931 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1941 W. Baltimore St
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1941 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Franklin Ferguson

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 216-10-1646

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edwina L. Ferguson
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Sept-11-1886

8. AGE: Years 58 | Months 6 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Maritime Police

11. Industry or business General

FATHER
12. Name William J. Ferguson
13. Birthplace Scotland

MOTHER
14. Maiden Name Emma J. Turner
15. Birthplace Maryland

16 (a) Informant Mrs. Edwina L. Ferguson (wife)
(b) Address 1941 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 17 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave, City

18 (a) Funeral director Jos. Jourdan's Sons
(b) Address 1927 Park Ave, City

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1945 at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24/44 19__ to March 14 1945, and that I last saw h~~im~~ alive on March 13 19 45.

Immediate cause of death	Duration
Tuberculosis of Lungs	1 year
Hemorrhage from Lungs	
Due to Mar March 14, 1945	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H G Jones M.D.
Address 2818 St. Paul St Date signed 3/14/45

VS 150

G26932

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G26932
CERTIFICATE OF DEATH 157E
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + 33rd
(c) Hospital or institution:
Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Roxton
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bowditch Hosp. School
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Robert C. Beck (ROBT. C. BECK)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife 0

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/20/38

8. AGE: Years 6 Months 11 Days 25 If less than one day hr. min.
1938 April 20

9. Birthplace Illinois
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Joseph C. Beck
13. Birthplace Illinois

MOTHER
14. Maiden Name Mary L. ?
15. Birthplace Illinois

16 (a) Informant Dr. Henry Bowditch
(b) Address Bowditch Hosp. School, Roxton

17 (a) Cremation (b) Date thereof 3-17-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Stewart Mayo & Co.
(b) Address 108 W Monroe.

19 (a) MAR 16 1945 (b) [illegible], Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1945, at 11 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1945 to March 16 1945 and that I last saw him alive on March 16 1945.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Ventricular fibrillation

Due to Congenital Heart Disease

Other Conditions Subdiaphragmatic ulcers
(Include pregnancy within 3 months of death)

Date of operation March 6

Major findings of operation: Subdiaphragmatic ulcers

Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Brigitte Nelson M. D.
Address Union Memorial Hosp Date signed 3/16/45

D X

G26933 | BALTIMORE CITY HEALTH DEPARTMENT | Registered No. G26933

CERTIFICATE OF DEATH 1937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 2601 Roslyn Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3526 Rolling Road -7
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERTHA E. BENNY

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles N. Benny
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1870

8. AGE: Years	Months	Days	If less than one day
75	1 0	13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Isaac D. Piersol
13. Birthplace Penna.

MOTHER
14. Maiden Name Margaret Thomas
15. Birthplace Virginia

16 (a) Informant Calvin P. Benny
(b) Address 3526 Rolling Road---7

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.

19 (a) Huntington Williams M.D. (Date rec'd by registrar)

MAR 16 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943, to March 15 1945. and that I last saw h. alive on 3-14 1945.

Immediate cause of death	Duration
Arteriosclerotic Cardio Renal	5 yrs
Due to Vascular Hypertension	5 yrs
Due to Hypertension Cardio Vas	
Other Conditions Disease	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J. Abbott M. D.
Address 4505 Liberty Heights Ave Date signed 3-15-45

G26934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G26934 Registered No.

Every item of information should be carefully supplied. Also write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 734 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ~~Laurel~~ LAURE Foster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Ok. Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 44 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Woodward, S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name John Foster
13. Birthplace S. C.

MOTHER 14. Maiden Name Jamie Foster
15. Birthplace S C.

16 (a) Informant Lizzie Foster
(b) Address 734 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-45 (month) (day) (year)
(c) Cemetery or crematory Red Hill
Location Woodward Timmonsboro, S. C.

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Blant Lee ave

19 (a) (Date) (Registrar) Huntington Williams, M.D. Registrar

MAR 16 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1945, at 10:30 A.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lymphosarcoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Preston M.D.
Medical Examiner
Date signed March 13 1945

(OVER)

X

626935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 626935

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville (Near Timonium) (If outside city or town limits, write RURAL and give town)
(d) Street No. York Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George M. Burns

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Martha (nee Ahelhurst)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 5, 1871

8. AGE: Years 74 | Months — | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Co. Md. (Town, county, and state)
10. Usual Occupation Bethlehem Steel Co.
11. Industry or business Retired

FATHER
12. Name Wm. Burns
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Virginia
15. Birthplace

16 (a) Informant Mrs. Rossie Ahelhurst
(b) Address Cockeysville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 19 1945 (month) (day) (year)
(c) Cemetery or crematory Jerusalem
Location Cockeysville Md
18 (a) Funeral director Lambdin McCauley
(b) Address Sparks, Md
19 (a) Date received MAR 16 1945 (b) Registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1945 at 9:10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1945 to March 16 1945, and that I last saw him alive on March 16 1945.

	Duration
Immediate cause of death Diabetic Acidosis and Uncontrolled Diabetes	
Due to Richters Hernia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: Strangulated Richters Hernia
of autopsy: Partial Intestinal obstruction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Roderick Shapley M. D.
Address University Hospital Date signed March 16 1945

G26936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G26936 Registered No. 467

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3204 Windsor Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 7
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3204 Windsor Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Virginia Teresa McConnell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Joseph S. McConnel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 17, 1856

8. AGE: Years	Months	Days	If less than one day
88	11	28	hr. min.

9. Birthplace Monkton, Balto. Co. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Peter Minnick
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Marsh
15. Birthplace Hereford, Balto. Co.

16 (a) Informant Mrs. Otto J. Newman
(b) Address 3204 Windsor Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Means & Son
(b) Address 805 N. Calvert St.
(c) (b)

MAR 17 1945
(Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1945 at 3.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1945 to Mar. 15, 1945 and that I last saw her alive on Mar. 14, 1945.

Immediate cause of death Carcinoma of Rectum — Duration 50 ays

Due to

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice T. Shamer

Address 3300 N. Potts Ave. Date signed 3/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

Registered No. 6937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 Winston Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John W Lyng

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
45 44	-	-	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Salesman

FATHER
12. Name Thomas J. Lyng
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary McGratta
15. Birthplace Ireland

16 (a) Informant Mrs Bessie Lyng
(b) Address 502 Winston Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Mary M Weedfeld
(b) Address 501 E. 32nd St

19 MAR 17 1945 Huntington Williams M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-15 1945, at 6:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13 1945 to 3-15 1945 and that I last saw him alive on 3-15 1945

Immediate cause of death: Respiratory Failure — Duration: —
Due to: Bronchopneumonia & Pulmonary edema — Duration: —
Due to: Subarachnoid Hemorrhage — Duration: 2 days
Other Conditions: Diabetes mellitus Hemochromatosis, cirrhosis of liver

Operation in 3 months of death

Date of operation none

Major findings of operation: none

of autopsy: Subarachnoid injury Hemochromatosis cirrhosis of liver hemorrhage of brain stem

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D Gleason M. D.
Address Univ Hospital Date signed 3-16-45

VS 150

82a

G26938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G26938 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 129 Willard st
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 129 Willard st
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Margaret M. Meyer.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Chas. A. Meyer
6 (c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) Oct. 17-1871
8. AGE: Years 73 | Months 4 | Days 27 | If less than one day ____ hr. ____ min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name John Menth
13. Birthplace Bavaria

MOTHER
14. Maiden Name Mary Seibert
15. Birthplace Balto Md

16 (a) Informant Mr. Chas. A. Meyer
(b) Address 129 Willard st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md

18 (a) Funeral director Geo. L. Beyer Jr
(b) Address 512 Hollins st

MAR 17 1945 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14 1945, at 9:52 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14 1945, to 3-14-1945, and that I last saw h— alive on 3-14 1945.

Immediate cause of death: Acute Dilatation of Heart
Due to: Chr Endocarditis & Myocarditis
Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
suddenly
20 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 190 Rutland Rd Date signed 3/16/45

G26939
B- 90656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G26939
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos- 19days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2624 Flora St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maude Whales

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8-1918

8. AGE: Years 27 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Pleas Whales (D)
13. Birthplace Va.

MOTHER
14. Maiden Name Helen Coles
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals-Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/45 (month) (day) (year)
(c) Cemetery or crematory Roanoke, Va
Location Va

18 (a) Funeral director Wm. G. Kelagan
(b) Address 1303 Pleasant St

19 (a) [illegible] (Date received by local registrar) MAR 17 1945 Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 19 45 at 5.50A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 19 44 to 3-15- 19 45.
and that I last saw her alive on 3-15 19 45

Immediate cause of death — Duration

Pulmonary Tuberculosis

Due to

Pulmonary Tuberculosis (1)

Due to

Other Conditions Arteriosclerosis Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Balto. Md. Date signed 3/16/45

X

626940

BALTIMORE CITY HEALTH DEPARTMENT X 626940
CERTIFICATE OF DEATH 13B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. If the exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maine (b) County
(c) City or town Kennebunk
(If outside city or town limits, write RURAL and give town)
(d) Street No. Green Trees (If rural, give R.F.D. and Summer St.
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

2. FULL NAME Lillian Louise Greene

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife William Greene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-20-74

8. AGE: Years 70 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation Writer

11. Industry or business

FATHER
12. Name Sylvester Gorby
13. Birthplace Kentucky

MOTHER
14. Maiden Name Laura McCloud
15. Birthplace Kentucky

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 17-1945 (month) (day) (year)

(c) Cemetery or crematory
Location Kennebunk Maine

18 (a) Funeral director Burgee Funeral Home
(b) Address 2421 Falls Road

19 (a) MAR 17 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1945, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 4 1945 to March 16 1945 and that I last saw h[illegible] alive on March 16 1945.

Immediate cause of death Exhaustion — Duration
Due to Tuberculosis Pulmonary
Due to Pyonephrosis
Other Conditions Diabetes
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marjorie L. McGee MD
Address Johns Hopkins Hosp Date signed 3/16/45

VS 150

G26941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G26941

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 137 W. Camden
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 137 W. Camden (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bertha Hicks Mitchell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12 1900

8. AGE: Years 45 | Months | Days 4 | If less than one day ... hr. ... min.

9. Birthplace South Mill, N.C. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name W A Mullen
13. Birthplace N.C.

MOTHER
14. Maiden Name Emma Sawyer
15. Birthplace N.C.

16 (a) Informant Minnie Wilson
(b) Address 124 W Perry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof mar 20 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem a.a.co. Md
Location

18 (a) Funeral director James A Adams
(b) Address 142 W. Hill St

19 (a) (Date received by registrar) (b) Registrar Huntington Williams, M.D.

MAR 17 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1945 at 12 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1943 to March 16 1945 and that I last saw her alive on 2/28 1945

Immediate cause of death Probably Uremia — Duration

Due to Carcinoma of Cervix with metastasis to Lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death).

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos L. Wilson M. D.
Address Univ. Hospital Date signed 3/16/45

626942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

626942 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied—the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos-7days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jane Fountroy

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April ?-1865
8. AGE: Years 79 | Months 11 | Days 15? | If less than one day ... hr. ... min.
9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Randall Fountroy
13. Birthplace Va.

MOTHER
14. Maiden Name Lavina Chatman
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals-Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 17, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Sara V. Hubbard
(b) Address 1631 Druid Hill Ave

19 (a) (Signature) (b) Huntington Williams

MAR 17 1945

VS 10

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15- 1945, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-8- 1945 to 3-15 1945, and that I last saw her alive on 3-15- 1945

Immediate cause of death	Duration
Lobar pneumonia	?
Due to TB.	
Due to	
Other Conditions Gen. arteria sclerosis Cerebral hemorrhage	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Woodward M. D.
Address Baltimore City Hospital Date signed 3-16-45

X

626943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

626943 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1434 W Baltimore St
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1434 W Baltimore St
(If rural give location)
(e) If foreign born, how long in U. S. A.? ✓ years

3 (a) FULL NAME Annie L Cronise

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife late John M. Cronise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6th 1874

8. AGE: Years 70 | Months 8 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation house work

11. Industry or business at home

FATHER 12. Name Michael Cooney
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary E. McGrogan
15. Birthplace Baltimore

16 (a) Informant Mrs. J. Leo Cooney
(b) Address 1434 W Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 19 '45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John F. Cowan & Son
(b) Address 901-03 Gilmor St

19 (a) MAR 17 1945 (Date received by registrar) Registrar of Vital Statistics, Baltimore, Md.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15th 1945, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1940, to 3-14 1945, and that I last saw h[illegible] alive on 3-13 1945.

Immediate cause of death	Duration
Arteriosclerotic heart disease	2
Due to generalized arteriosclerosis	3
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations –
Of autopsy –

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide –
(b) Date of occurrence –
(c) Where did injury occur? – (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? – While at work? –
(Specify type of place)
(e) Means of injury –

23. Signature M. B. Schreiber M.D.
Address 543 S. Fulton Ave Date signed 3-16-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

626944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

626944 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1924 Wilkens Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1924 Wilkens Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Sipes

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6th 1861.

8. AGE: Years	Months	Days	If less than one day
83.	5	9	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation house work.
11. Industry or business at home

FATHER
12. Name Ephriam Sipes
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Elizabeth Frybogle
15. Birthplace Baltimore Md.

16 (a) Informant Agnes R. Sipes
(b) Address 1924 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olive Cem,
Location Roslyn Md
18 (a) Funeral director John J. Cowan & Son
(b) Address 901-903 Baltimore St.
19 (a) MAR 17 1945 (Date rec'd by registrar) (b) Huntington Williams 3-5297

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15 1945, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940, to March 15 1945, and that I last saw h.r alive on Mar 15 1945.

Immediate cause of death	Duration
Coronary Thrombosis	3 weeks
Due to	
Due to	
Other Conditions Arteriosclerotic C.V. disease (Include pregnancy within 3 months of death)	5 yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. J. Sullivan M.D.
Portsmouth R.I. Date signed 3/15/45

VS 150

G26945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G26945

Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1804 Longwood St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 Longwood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary H. Dyer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14 1874

8. AGE: Years	Months	Days	If less than one day
70	11	1	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Dyer
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Muldoon
15. Birthplace Ireland

16 (a) Informant Katherine Dyer
(b) Address 1804 Longwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 W. North Ave.

19 (a) MAR 17 1945 (b) Huntington Williamsburg, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1945, at 9:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 19YY to March 15 1945, and that I last saw h[illegible] alive on March 15 1945.

Immediate cause of death: Cardiac failure. — Duration

Due to: Cardio Vascular Renal Disease

Due to: Generalized Arteriosclerosis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. E. Needle, M. D.
Address 7314 - W. North Ave. Date signed 3/17/45

X

G26946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G26946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2413 E.Biddle Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F.Brandt

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Margaret Brandt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28,1869

8. AGE: Years	Months	Days	If less than one day
75	7	18	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name -- Brandt
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs.Thelma George
(b) Address 2413 E.Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar.19/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Balto. Md.

18 (a) Funeral director Philip Haury Sons
(b) Address 2024 Orleans St.

MAR 17 1945 (Date rec'd by Registrar) Huntingtown Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15/45, 19..., at ...M

21. I certify that death occurred on the date above stated that I attended deceased from 19... to 19... and that I last saw him alive on 19...

Immediate cause of death	Duration
Pulmonary Arrest	10 day
Due to Edema	
Due to Nephritis	
Other Conditions Arteriosclerosis	

(Include pregnancy within three months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ...M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature
Address 600 N. Patterson Park Ave

VS 150

G26947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G26947 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.,
(c) Hospital or institution:
U.S. Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 W. 28th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank William Edmonds

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: col

6 (a) Single, married, widowed, or divorced. Mar.

6 (b) Name of husband or wife Sally Edmonds

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1900

8. AGE: Years 44 | Months 2 | Days 20 | If less than one day hr. min.

9. Birthplace Alberta, Virginia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Nick Edmonds
13. Birthplace Virginia

MOTHER
14. Maiden Name Sally Johnson
15. Birthplace Virginia

16 (a) Informant Records-US Marine Hospital
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-18-45 (month) (day) (year)

(c) Cemetery or crematory
Location Alberta, Virginia

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date received) MAR 17 1945 (b) Huntington & Holloway, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1945, at 9:55 am M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8, 1945, to Mar. 16, 1945, and that I last saw him alive on Mar. 16, 1945.

Immediate cause of death: Pulmonary tuberculosis, far advanced — Duration: 5 yr.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin D. Jones M. D.
Address US Marine Hospital Baltimore, Maryland Date signed 3/17/45

G26948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G26948 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3430 Mt.Pleasant Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3430 Mt.Pleasant Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Justice Foltz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife: John August Foltz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1884

8. AGE: Years	Months	Days	If less than one day
60	11	4	hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: At home

11. Industry or business

FATHER
12. Name: John Samuel Roth
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Mary S. Holt
15. Birthplace: Baltimore Md.

16 (a) Informant: George Roth
(b) Address: 1616 Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar.19,1945 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cem.
Location: Taylor Ave.

18 (a) Funeral director: John C. Miller Inc.
(b) Address: 2435 E. Oliver St.

19 (a) (b) (Registrar) Registrar

MAR 17 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar.16,1945 19 , at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-6-45 19 , to 3-16-45 19 , and that I last saw h alive on 19

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Arteriosclerosis & Hypertension	
Due to	
Other Conditions Senile Meltitus	1 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John C. Armstrong, MD M. D.

Address 2 [illegible] Corbury St. Date signed 3-16-45

93D

626949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

626949

Registered No.

100 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Reisterstown, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hammond

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles Hammond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1896

8. AGE: Years 48 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name David Yellott
13. Birthplace Md.
14. Maiden Name Emily Morris
15. Birthplace Md

16 (a) Informant Charles Hammond
(b) Address Reisterstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 20-45 (month) (day) (year)
(c) Cemetery or crematory All Saints
Location Reisterstown Md.

18 (a) Funeral director J. F. Elsner Sons
(b) Address Reisterstown Md.

19 (a) MAR 17 1945 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1945, at 1 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13 1945 to 3/17 1945, and that I last saw her alive on 3/17 1945

Immediate cause of death Pulmonary embolism due to phlebitis of left leg

Due to none

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers
Address Franklin Sq. Hosp. Date signed 3/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6269 50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

6269 50 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address - Redwood & Greene
(c) Hospital or institution:
University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. 36 Bond St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Fisher Cover

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Bessie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
64 63			hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business self.

FATHER
12. Name Harry Cover
13. Birthplace Maryland.

MOTHER
14. Maiden Name Doras Hitchcock
15. Birthplace Maryland.

16 (a) Informant Mrs. Hilda Shaum
(b) Address Hoffmanstn, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 19-45 (month) (day) (year)
(c) Cemetery or crematory Krider's Cem.
Location Hoffmanstn Md

18 (a) Funeral director J. E. Myers Jr.
(b) Address Westminster Md

19 (a) (Date rec'd by registrar) (b) Huntington Williams

MAR 17 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17/45 19 at 5:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1945 to 3/17 1945.
and that I last saw h~~im~~ alive on 3/16 1945.

Immediate cause of death	Duration
— Coronary occlusion - old & silent arteriosclerosis (V.D.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. W. Mintzer M. D.
Address Univ. Hosp. Date signed 3/17/45

X

626951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

626951 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully recorded. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 629 N. Paca Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Faison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1912

8. AGE: Years 32 | Months 3 | Days 7 | If less than one day hr. min.

9. Birthplace Clinton, N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Frank Faison

13. Birthplace N.C.

MOTHER 14. Maiden Name Mattie Van

15. Birthplace N.C.

16 (a) Informant Mattie Faison

(b) Address 629 Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-45 (month) (day) (year)

(c) Cemetery or crematory Warsaw, Location North Carolina

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Avenue

19 (a) MAR 17 1945 Certificate received by registrar Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 45, at 10:10 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Shock

Due to Multiple Fractures

Other Conditions Acute Congestion & edema of lungs.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-13-45 at 6:20 A. M. 17/3
about 15 ft. south of Myrtle Ave.
(b) Where did injury occur? at Mulberry & Paca Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? no.
Means of injury Pedestrian struck by auto.

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed March 15 1945.

G26952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G26952

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 308 E. 20½ St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 308 E. 20½ St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1888

8. AGE: Years	Months	Days	If less than one day
56	3		hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Williams
13. Birthplace Va.

MOTHER
14. Maiden Name Moore
15. Birthplace Va.

16 (a) Informant Marie Brayton
(b) Address 2206 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) (Signature of Registrar) (b) Huntington Williams, M.D. Registrar

MAR 17 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 14, 1945 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-6-45 19 , to 3-14- 1945
and that I last saw h[illegible] alive on 3-12- 1945.

Immediate cause of death Arteriosclerotic Heart Disease — Duration ?

Due to

Due to

Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice Adams, M. D.
Address 312 E 23rd St Date signed 3-16-45

X

G26953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1463

Registered No. G26953

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 pitman place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 pitman place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas J. Holden Sr.

3 (b) If veteran, name war — No —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah N. McDonough-Holden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22 1883

8. AGE: Years 61 | Months 10 | Days 15 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER 12. Name Matthew Holden
13. Birthplace Ireland

MOTHER 14. Maiden Name Ann Kavanagh
15. Birthplace Ireland

16 (a) Informant Mrs. Sarah N. Holden
(b) Address 416 Pitman Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 20/45 (month) (day) (year)
(c) Cemetery or crematory Mayo Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director Edmund W. Conklin & Son
(b) Address 326 E. Eagle St. Huntington, W. Va.

19 (a) MAR 17 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 15, 1945, at 8:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1944 to 3/15 1945, and that I last saw h[illegible] alive on 3/15 1945

Immediate cause of death Carcinoma of Stomach

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 6 Mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Bloom M. D.
Address 1206 E. Preston St. Date signed 3/16/45

G26954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G26954

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104 E. Preston St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James W. Kelly

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1886

8. AGE: Years	Months	Days	If less than one day
58	3	5	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Waiter in Restaurant
11. Industry or business McKeldin Brothers

FATHER
12. Name John J. Kelly
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary E. Chase
15. Birthplace Baltimore Md.

16 (a) Informant Miss F. Virginia Kelly
(b) Address 1104 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 19, 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location 4300 Old Frederick Rd

18 (a) Funeral director Elmer W. Compton
(b) Address 924 E. Eager St.

19 MAR 17 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 16, 1945 at 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7- 1944 to 3-15- 1945, and that I last saw him alive on 3-12- 1945.

Immediate cause of death: Cerebral degeneration — Duration: 6 mos.
Due to Arteriosclerosis — Duration:
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred B. Sybert M. D.
Address 2807 Harford Rd Date signed 3-16-45

X

G26955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

Registered No. G26955

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Arlington (If outside city or town limits, write RURAL and give town)
(d) Street No. 2845 So. Buchanan St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosemary Lindsay

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ray Lindsay

6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) 6-27-17

8. AGE: Years	Months	Days	If less than one day
27	8	19	hr. min.

9. Birthplace Illinois (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name James N. Sullivan
13. Birthplace Ill.

MOTHER — 14. Maiden Name Lucille Kelly
15. Birthplace Ill.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial Report (Burial, cremation, or removal) (b) Date thereof 3/17/45 (month) (day) (year)

(c) Cemetery or crematory Washington D.C.
Location

18 (a) Funeral director L. H. Hines
(b) Address Wash D.C.

19 (a) Date received by local registrar MAR 17 1945 (b) Signature of local registrar Elizabeth Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1945, at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 12 1945, to March 16 1945, and that I last saw h[illegible] alive on March 14 1945.

Immediate cause of death	Duration
Respiratory Collapse	
Due to Tuberculous Meningitis	3½ wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laura Dickson
Address Johns Hopkins Date signed 3/17/45 M.D.

626956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164 C

Registered No. 626956

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1528 John St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Raymond E Welsch (~~Welsh~~) (Welsh)

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. .....

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1892

8. AGE: Years 52 | Months 8 | Days 16 | If less than one day ..... hr. ..... min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name Henry Welsch (~~Welsh~~) (Welsh)
13. Birthplace Bedford Co. Pa.

MOTHER
14. Maiden Name Maria Bequeath
15. Birthplace Pa.

16 (a) Informant Mrs. Charles Diehl
(b) Address Everett Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/17/45 (month) (day) (year)
(c) Cemetery or crematory .....
Location Everett, Pa.

18 (a) Funeral director Wm. J. Tiernan Sons
(b) Address North Pa. Ave

19 (a) MAR 17 1945 (Date rec'd by registrar) Huntingdon Pa. (b) .....

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1945, at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound
of Head

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March M.
(b) Where did injury occur? 1528 John St.
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Shot Self

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 3-17-45

(OVER)

G26957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 65a ✓

Registered No. G26957

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 543 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 543 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin B. Gibson.

3 (b) If veteran, name war None.

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single.

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 20 1912.

8. AGE: Years 32 | Months 9 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Paper hanger.

11. Industry or business

FATHER
12. Name Frank B. Gibson.
13. Birthplace Md.

MOTHER
14. Maiden Name Etta J. Bynon.
15. Birthplace Md.

16 (a) Informant Mrs. Etta J. Anzula.
(b) Address 543 N. Fulton Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 18 45. (month) (day) (year)
(c) Cemetery or crematory Stevensville Cemetery
Location Stevensville Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 505 N. Monroe St.

19 (a) MAR 18 1945 (b) by registrar Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15th 1945, at 4.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1 visit 19 to 19, and that I last saw h alive on 19.

	Duration
Immediate cause of death Myocardial failure	3 days
Due to Addison's Disease	?
Due to	
Other Conditions Bronchial Asthma	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Coolahan M. D.
Address 24 N. Fulton Ave Date signed 3/17/45

VS 150

626958 | BALTIMORE CITY HEALTH DEPARTMENT | 626958
CERTIFICATE OF DEATH | 131a | Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2121 N. Howard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 N. Howard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Freeman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1885

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Simon Stokes
13. Birthplace Va

MOTHER
14. Maiden Name Mary ?
15. Birthplace Va.

16 (a) Informant Marie Rice
(b) Address 2121 N. Howard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 19 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Balto County Md

18 (a) Funeral director Mrs. Robert E. Elliott & Dgt.
(b) Address 1429 N. Caroline St. (Huntington Williams, M.D.)

19 (a) (b) Registrar
Rec'd by registrar 8 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1945, at 4:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 1 1945 to Mch 16 1945, and that I last saw h[illegible] alive on Mch 15 1945

Immediate cause of death: Cardiac Renal Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis A. Klein M.D.
Address 2829 Gwynns Date signed Mch. 17 1945

G26959 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G26959

CERTIFICATE OF DEATH 126

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood - Greene St
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Logue
3 (b) If veteran, name war
3 (c) Social Security Account No. None
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Elmer Logue
6 (c) If alive, give age 62 years
7. Birth date of deceased (mo., day, yr.) 1883
8. AGE: Years 62 Months Days If less than one day hr. min.
9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name George Bitzel
13. Birthplace Maryland
MOTHER 14. Maiden Name Susan Miles
15. Birthplace Maryland
16 (a) Informant
(b) Address
17 (a) Burial (b) Date thereof 3-21-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Deer Park
Location Smallwood
18 (a) Funeral director J. S. Reese
(b) Address Westminster Md.
19 (a) 845 Huntington Williams M.D. Registrar
(Registered by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18-45 19 at 12:45 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 19 45 to 3-18 19 45, and that I last saw h er alive on 12-15 19 45.

	Duration
Immediate cause of death Exhaustion, Cardiac failure	
Due to Jaundice	
Due to Portal edema of Bile Ducts	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)
Date of operation 3-13-45
Major findings of operations Multiple Gallstones
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? no (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature D Gleason M. D.
Address Univ Hosp Date signed 3-18-45

VS 150

G26960 BALTIMORE CITY HEALTH DEPARTMENT G26960

CERTIFICATE OF DEATH 169

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. Balto. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 McKean Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Ann Coffey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1933

8. AGE: Years 11 | Months 6 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Rockbridge Co., Va.
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name James Coffey
13. Birthplace Rockbridge Co., Va.

MOTHER
14. Maiden Name Anna Thompson
15. Birthplace Wise Co., Va.

16 (a) Informant Mr. James Coffey
(b) Address 1112 McKean Ave.

17 (a) Removal (b) Date thereof 3/18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Buena Vista, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 18 1945 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16- 1945 at 7:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Head, with avulsion of brain tissue.

Due to

Other Conditions Traumatic amputation through chest with evisceration of organs.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 3-16- at 16/4 P. M.

(b) Where did injury occur? R. R. tracks, Appleton & Riggles

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no

(d) Means of injury Pedestrian-train passed through body.

23. Signature Howard J. Mueller M.D.
Medical Examiner.

Date signed 3-17-45

G26961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G26961 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Rochester Court Apt 2 A.
(c) Hospital or institution: Linden Ave & Brooks Lane
(d) Length of stay in hospital or inst. (yrs., mos., or days): 13
(e) Length of stay in Baltimore (yrs., mos., or days): 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: Rochester Court Apt 2 A. (If rural give location)
(e) Citizen of foreign country?: (Yes or No)
If yes, name country:

3 (a) FULL NAME: Etta Scherr

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Late Herman
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 1, 1875

8. AGE: Years	Months	Days	If less than one day
70	2	16	hr. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual Occupation:

11. Industry or business: House Work

FATHER
12. Name: Louis Amolsky
13. Birthplace: Riga

MOTHER
14. Maiden Name: Katherine Siegel
15. Birthplace: Riga

16 (a) Informant: Jerome Scherr
(b) Address: Rochester Court Apt 2 A.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 19 45 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Friendship Cem
Location: 3600 E Baltimore St

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) 1945 (Date rec'd by registrar) (b) Washington Williams, M Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17 1945, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943, to March 17 1945, and that I last saw h[illegible] alive on March 16 1945.

Immediate cause of death	Duration
Pulmonary Embolism	
Due to Coronary Thrombosis	
Due to Arteriosclerosis.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury: W. E. Needle

23. Signature:
Address: 1314 - W. North Ave. Date signed: 3/19/45 M. D.

G26962

BALTIMORE CITY HEALTH DEPARTMENT ✓ G26962

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2802 E. Baltimore St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2802 E. Balto St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Travers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Capt. John M. Travers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 3rd 1868

8. AGE: Years	Months	Days	If less than one day
76	3	14	hr. min.

9. Birthplace Wicomico Co.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Winder Davis
13. Birthplace Wicomico Co.

MOTHER
14. Maiden Name
15. Birthplace Wicomico Co.

16 (a) Informant Hilda Goetzke
(b) Address 2802 E. Balto. St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 20, 45 (month) (day) (year)
(c) Cemetery or crematory Int. Carmel
Location O'donnell St

18 (a) Funeral director Frank V. Pepitone
(b) Address 2[illegible] Baltimore, Md

MAR 18 1945

19 (a) (Date rec'd by registrar) (b) Registrar
Thurgood Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1945, at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/17 1944 to 3/17 1945, and that I last saw h[illegible] alive on 3/16 1945.

Immediate cause of death

Due to Cerebral Hemorrhage

Due to Chronic Myocarditis

Duration
12 hrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Virgil L. Dudley, M.D.
Address 3336 Balto Date signed 3/17/45

X

G26963 BALTIMORE CITY HEALTH DEPARTMENT ✓ G26963

CERTIFICATE OF DEATH 33a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3908 Fairhaven Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 Fairhaven Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Neal Mullins

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 30. 1945

8. AGE: Years	Months	Days	If less than one day
	1	17	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Alvin B. Mullins
13. Birthplace Virginia

MOTHER
14. Maiden Name Mae C. McFall
15. Birthplace Virginia

16 (a) Informant Alvin B. Mullins (Father)
(b) Address 3908 Fairhaven Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 18 1945 (month) (day) (year)
(c) Cemetery or crematory Bluemont
Location Virginia

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

MAR 18 1945 (Date rec'd by registrar) (b) Huntington Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1945 at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to 19..., and that I last saw h... alive on 19...

Immediate cause of death: Influenzal Pneumonia — Duration 2 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. L. Ball Jr. M. D.
Address Linthicum Heights Date signed 3-17-45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G26964 ✓ G26964 Registered No. 121a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3016 E. Fayette St.
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city limits write RURAL and give town)
(d) Street No. 3016 E. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbara Vogel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4 Sex: Female | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Frank.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 17-1869

8. AGE: Years 75 | Months 76 | Days 29 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Housework.
11. Industry or business

FATHER 12. Name Doetzer
13. Birthplace Germany

MOTHER 14. Maiden Name —
15. Birthplace —

16 (a) Informant
(b) Address 3016 E. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 19-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rest.
Location Beltsville Md.

18 (a) Funeral director Thos. E. McGrath
(b) Address 3016 E. Baltimore St.

19 (a) MAR 18 1945 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1945, at 5:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2, 1942, to Mar. 15, 1945, and that I last saw her alive on Mar. 15, 1945

	Duration
Immediate cause of death: Congestive Heart Failure	5 hours
Due to: Arteriosclerosis	Unknown
Chronic Myocarditis	Unknown
Due to: Chronic Endocarditis	Unknown
Chronic Nephritis	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip Antignani
Address 2942 E. Fayette St. Date signed 3/17/45

VS 190

G26965 ✓ G26965

G26965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 Springfield Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 706 Springfield Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward D. White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~. Married

6 (b) Name of husband or ~~wife~~ Marie S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30-1859

8. AGE: Years 85 81 | Months 11 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Alexander J. White

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name M Altigs

15. Birthplace England

16 (a) Informant Marie S. White

(b) Address 706 Springfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 19-45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Frederick Road

18 (a) Funeral director John C. Moran

(b) Address 3000 E Baltimore St

19 (a) 1945 (b) Registered by registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1945 to 3/16 1945, and that I last saw him alive on 3/16 1945.

Immediate cause of death Coronary occlusion. — Duration Sudden.

Due to Myocardial degeneration with abdominal aortic.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Willis Guyton

Address 3963 Greenmount Ave Date signed M. 3/17/45 D.

VS 150

G26966 Sirasky ✓ G26966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City Maryland
(b) Street address Monument & Lutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 302 Temple Gardens Apts (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sarah Sirasky

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Joseph | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Abraham Isaac Potoff
13. Birthplace Russia

MOTHER 14. Maiden Name Freida Selda
15. Birthplace Russia

16 (a) Informant Family
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1739 E. Balto St

19 (a) 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 1945, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16 1945 to 3/16 1945, and that I last saw h/ alive on 3/16 1945

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Fall & Trauma of broken leg.	
Due to	
Other Conditions Heart failure	

(Include pregnancy within 3 months of death)

Date of operation 3/16/45
Major findings of operation: Fracture left leg
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically 1/1

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 3/16/45 at 12:15 P.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no (Specify type of place)
(e) Means of injury Pt fell & broke leg

23. Signature Dr. H. M. Greenberg
Address Sinai Hospital Date signed 3/16

Approved: Robert Levi Gutman M.D. 3/18/45

G26967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G26967 Registered No. 830a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3530 Ellerslie Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lillian M. Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Mr. W. O. Snyder
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1885

8. AGE: Years	Months	Days	If less than one day
59	4	22	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Weaver
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Smith
15. Birthplace Md

16 (a) Informant Mrs Earl Apfelbaum
(b) Address Hampstead Md

17 (a) Burial (b) Date thereof Mar 20 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Wesley
Location Carroll Co Md

18 (a) Funeral director Eder & Upton
(b) Address Hampstead Md

MAR 18 1945 (b)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/18 1945 at 3:24 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1945 to 3/18 1945 and that I last saw h alive on 3/17 1945.

Immediate cause of death Cardiorespiratory failure — Duration

Due to Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D Morris M.D.
Address [illegible] Date signed 3/18/45
M. D.

G26968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G26968
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2705 Allendale
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 ??
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2705 Allendale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLEN FRANCES GILES

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William Trickett Giles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1882

8. AGE: Years	Months	Days	If less than one day
62	5	4	hr. min.

9. Birthplace Somerset Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wilbur J. Thomas
13. Birthplace Somerset Co., Md.

MOTHER
14. Maiden Name Mary Frances Anderson
15. Birthplace Somerset Co., Md.

16 (a) Informant Ellen F. Giles, Lt. jg.
(b) Address 2705 Allendale Rd.

17 (a) Burial (b) Date thereof 3/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 18 1945 (b) for Williams, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1945 at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 1945, to March 16 1945, and that I last saw h~~e~~r alive on March 11 1945.

	Duration
Immediate cause of death Coronary occlusion	10 min.
Due to Cardio Coronary vascular disease	2 mo.
Due to	
Other Conditions Arteriosclerosis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of ~~occurrence~~ at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter L. Dublin M. D.
Address 222 W Harrison Date signed March 17/45

VS 150

G26969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830a

G26969 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3205 Walbrook Ave.
(c) Hospital or institution: 15 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3205 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: ANNA AMELIA LaFLEUR

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Walter Scott LaFleur

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1865

8. AGE: Years	Months	Days	If less than one day
80	1	0	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Louis Page
13. Birthplace --

MOTHER
14. Maiden Name Elizabeth Schatz
15. Birthplace Germany

16 (a) Informant Miss Lee LaFleur
(b) Address 3205 Walbrook Ave.

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Huntington Williams Registrar

MAR 18 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1945, at 2:10A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to March 17 1945 and that I last saw h alive on 19

Immediate cause of death: Cerebral Hemorrhage and paralysis — Duration: 2 days

Due to

Due to

Other Conditions Advanced arterio-sclerosis — Duration: 9

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Dublett M. D.
Address 222 Harrison Blvd. Date signed March 17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26970 G26970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Ave
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A.A.
(c) City or town Annapolis (If outside city or town limits, write RURAL and give town)
(d) Street No. 157 West Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John R. Chaney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 1880

8. AGE: Years	Months	Days	If less than one day
64	10	11	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Gas & Elec Co

FATHER 12. Name Samuel Chaney

13. Birthplace Md

MOTHER 14. Maiden Name Emma Lanham

15. Birthplace Md

16 (a) Informant Lawrence Chaney

(b) Address 4006 N Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 19-45 (month) (day) (year)

(c) Cemetery or crematory Ivy Hill

Location Laurel Md

18 (a) Funeral director Floyd Kaiser

(b) Address Laurel Md.

19 (a) 3-18-1945 (Date rec'd by registrar) (b) Registrar Thurlington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1945, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 1945, to March 16 1945, and that I last saw him alive on March 16 1945.

Immediate cause of death	Duration
Carcinoma of the neck	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. H. Patterson

Address 2324 Reisterstown Rd Date signed 3/17/45 M. D.

G26971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G26971 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2122 Jefferson (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Genevieve Gaphardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-27-12

8. AGE: Years 32 | Months 2 | Days 17 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER 12. Name Michael O'Connor

13. Birthplace Md.

MOTHER 14. Maiden Name Mary Keller

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/45 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Balto. Md.

18 (a) Funeral director J. F. Kleman Son

(b) Address 32 S. Broadway

19 (a) MAR 20 1945 (Date received by registrar) (b) Irving for Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1945, at 1.26 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 12 1945 to Mar 14 1945 and that I last saw her alive on Mar 14 1945

Immediate cause of death: Lobar pneumonia, bilateral, involving all 5 lobes. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert A. Kaller, M.D.

Address Johns Hopkins Hosp. Date signed 3/19/45

G26972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G26972 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., ~~mos., or days~~) 11
(e) Length of stay in Baltimore (yrs., ~~mos. or days~~) 82

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 16 W. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank E. Sherwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11, 1862

8. AGE: Years 82 | Months 6 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Painter & Decorator

11. Industry or business Painting & Decorating

FATHER
12. Name James A Sherwood
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary C Hewitt
15. Birthplace Baltimore

16 (a) Informant Self
(b) Address

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/20/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Balto. Md.
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St
(c) Huntington Williams, M.D.

MAR 18 1945 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 1945 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1945 to 3/16 1945.
and that I last saw him alive on 3/16 1945

	Duration
Immediate cause of death Cardiac Failure	
Due to Bronchial Pneumonia	4 days
Due to General Debility & Remaining in bed	11 days
Other Conditions Fract Rt Femur	11 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 3/5/45 at M
(c) Where did injury occur? 16 W. Preston St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Slipped and Fell on Floor

23. Signature Charles E. O'Donnell M.D.
Address Mercy Hospital Date signed 3/18/45

Patient Expired 3/16/45 X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G26973 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1328 N Lemmond Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Riviera Beach
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter S Myers

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16 1878

8. AGE: Years 67 | Months 2 | Days | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Edward Myers
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Sivers
15. Birthplace Md

16 (a) Informant Mrs John Overton
(b) Address 1328 N Lemmond Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Md
Location Anne Arundel Co
18 (a) Funeral director Tilghman Corkran
(b) Address 1217 E Fort Ave

19 (a) MAR 18 1945 (Entered by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1945, at 9:25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20, 1945, to Mar. 16, 1945, and that I last saw him alive on Mar. 16, 1945.

Immediate cause of death	Duration
Carcinoma of the Sigmoid Colon with Metastasis to liver, etc.	Unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philbert Antignani M. D.
Address 2942 E. Fayette St. Date signed 3/17/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G26974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G26974 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2733 Md. ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Schultz

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
World War #1	154-05-3432	Male	White	Married

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22nd 1895

8. AGE: Years	Months	Days	If less than one day
49	3	24	hr. min.

9. Birthplace San Antonio Texas
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Winifred Leishear

FATHER
12. Name John Schultz
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Wright
15. Birthplace Va

16 (a) Informant Mrs Margaret Schultz
(b) Address 2733 Maryland Ave

17 (a) Removal (b) Date thereof Mar 21 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Arlington
Location Philadelphia Pa

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 127 St. Paul St.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 16th 1945, at 2 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Multiple fractures

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-16- at 2 1/2 P. M.
(b) Where did injury occur? 211 Sharp St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? yes.
(d) Means of injury Fell from scaffold

23. Signature Howard D. Williams M.D.
Medical Examiner.
Date signed 3-17-45

VS 151

345756 G26975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

G26975

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Olean (If outside city or town limits, write RURAL and give town)
(d) Street No. 219 N First St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Day Hagadorn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Ella A Hagadorn

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) 5-25-64

8. AGE: Years	Months	Days	If less than one day
80	9	23	hr. min.

9. Birthplace Penn. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George W. Hagadorn
13. Birthplace N.Y.

MOTHER
14. Maiden Name Mary Jane Hoag
15. Birthplace Scotland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 20/45 (month) (day) (year)

(c) Cemetery or crematory Olean Cemetery
Location Olean N.Y.

18 (a) Funeral director John C. Mulstell & Sons
(b) Address 920 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

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MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 - 1945 at 7 25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7- 1945 to 3-17- 1945 and that I last saw h alive on 3-17- 1945

Immediate cause of death	Duration
Overwhelming Septicemia	
Due to Infection following Transurethral resection	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation March 9, 1945

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury.

23. Signature Edw. J. Beloncon Jr M.D.
Address Johns Hopkins Hosp. Date signed 3/17/45

CITY HALL
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 8-12 DAY OF 1963 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH 24501 AND ENDING WITH 26975 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: Loretta Byrne



END OF REEL